

10927 CERTIFICATE OF DEATH

10896

Reg. Dist. No.

77

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harmans</u>				c. LENGTH OF STAY IN 1b <u>1 mo.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Shipley Ave</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Melitta Grace Applequist</u>				4. DATE OF DEATH <u>Nov 6 1956</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-13-19</u>	
9. AGE (In years last birthday) <u>37</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		11. BIRTHPLACE (State or foreign country) <u>Balto Co</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Henry J. Baumgartner</u>				14. MOTHER'S MAIDEN NAME <u>Annie C. Hartline</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>218-09229</u>			
17. INFORMANT <u>Kernut Baumgartner</u>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULMONARY EDEMA</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CONGESTIVE HEART FAILURE</u> DUE TO (c) <u>METASTATIC CARCINOMA LEFT BREAST</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH <u>11 HRS.</u> <u>3 DAYS.</u> <u>9 MOS.</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from <u>11-5</u> , 19 <u>56</u> , to <u>11-7</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>11-7</u> , 19 <u>56</u> , and that death occurred at <u>2:21 A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Leon C. Perry</u>				ADDRESS (Street, city or town, state) <u>201 B & A BLVD, GLEN BURNIE, MD.</u>			
PHYSICIAN'S NAME (Type) <u>LEON C. PERRY, M.D.</u>				DATE SIGNED <u>11-7-56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>11/9/56</u>		<u>Immanuel Cem</u>		<u>Balto MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Paul G. Neumann</u>				ADDRESS <u>6067 Hay Rd</u>		24a. REC'D BY REGISTRAR <u>NOV 9 1956</u>	
24b. REGISTRAR'S SIGNATURE <u>Clara Taylor</u>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

NOV 9 1956

BUREAU V. 2

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10899 CERTIFICATE OF DEATH

Reg. Dist. No. 21

10897

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital		d. STREET ADDRESS 106 N. Linden Ave.	
3. NAME OF DECEASED (Type or print) First FRANK Middle G Last BALDWIN SR		4. DATE OF DEATH Month November Day 12 Year 19 56	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 7, 1898
9. AGE (In years last birthday) 58 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Proprietor		10b. KIND OF BUSINESS OR INDUSTRY Farm Equipment Co	
11. BIRTHPLACE (State or foreign country) Millersville, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William E. Baldwin Sr.		14. MOTHER'S MAIDEN NAME Annastusia A. Deutsch	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-16-4735	
17. INFORMANT Mrs Belle Baldwin- Wife- Same as # 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis & Block 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c) UNKNOWN INTERVAL BETWEEN ONSET AND DEATH 20 DAYS			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from July 4, 1954 , to 12 Nov. 1956 , that I last saw the deceased alive on 12 Nov. 1956 , and that death occurred at 7:20 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 41 Southgate Ave Annapolis 11/4/56 ACTUAL SIGNATURE Edward S. Beck M.D. PHYSICIAN'S NAME (Type) Edward S. Beck M D 41 Southgate Ave, Annapolis, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Nov. 15, 1956	22c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery	22d. LOCATION (City, town, or county) (State) Annapolis, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE HOPPING FUNERAL HOME		24. REC'D BY REGISTRAR ANNAPOLIS, MARYLAND	

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10928 CERTIFICATE OF DEATH

Reg. Dist. No.

10898

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore City</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>				c. LENGTH OF STAY IN 1b <u>10 mos. 6 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore City</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crownsville State Hospital</u>				d. STREET ADDRESS <u>1600 N. Gilmore St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Ethel</u> Middle <u>Barnes</u> Last <u>Barnes</u>				4. DATE OF DEATH Month <u>11</u> Day <u>12</u> Year <u>19 56</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8/4/00</u>	
9. AGE (In years last birthday) <u>56</u> yrs.		IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>		IF UNDER 24 HRS. Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>— — — —</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>							
13. FATHER'S NAME <u>Alphonsus Curtis</u>				14. MOTHER'S MAIDEN NAME <u>Mary Curtis</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unk.</u>		(If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Unk.</u>		17. INFORMANT <u>Hospital Records</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>442x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Renal Failure</u> DUE TO (c) <u>Hypertensive Cardiovascular Disease</u>				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypostatic Pneumonia, Decubitus Ulcers</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7/9</u> , 19 <u>56</u> , to <u>11/12</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>11/9</u> , 19 <u>56</u> , and that death occurred at <u>12:10 p. m.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Crownsville, Md.</u> DATE SIGNED <u>11/13/56</u> ACTUAL SIGNATURE <u>Lionel McHenry Mapp</u> M.D. PHYSICIAN'S NAME (Type) <u>Lionel McHenry Mapp</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>11/20/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Peter's Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>George L. Nelson</u>				ADDRESS <u>1348 W. Calhoun</u>		24a. REC'D BY REGISTRAR <u>NOV 19 1956</u>	
				24b. REGISTRAR'S SIGNATURE <u>A. M. Joyce</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

<p>1. NAME OF DECEASED JAMES EARL RAY</p>		<p>2. SEX Male</p>		<p>3. AGE 35</p>		<p>4. DATE OF BIRTH Jan 5, 1928</p>		<p>5. PLACE OF BIRTH Jackson, Mississippi</p>	
<p>6. OCCUPATION Attorney</p>		<p>7. MARITAL STATUS Single</p>		<p>8. COLOR White</p>		<p>9. HEIGHT 5' 10"</p>		<p>10. WEIGHT 175</p>	
<p>11. CAUSE OF DEATH Suicide</p>		<p>12. MANNER OF DEATH Homicide</p>		<p>13. PLACE OF DEATH Birmingham, Alabama</p>		<p>14. DATE OF DEATH April 4, 1968</p>		<p>15. TIME OF DEATH 2:01 PM</p>	
<p>16. SIGNATURE OF PHYSICIAN [Signature]</p>		<p>17. SIGNATURE OF CORONER [Signature]</p>		<p>18. SIGNATURE OF WITNESS [Signature]</p>		<p>19. SIGNATURE OF WITNESS [Signature]</p>		<p>20. SIGNATURE OF WITNESS [Signature]</p>	

BUREAU V. S.

NOV 19 1968

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UNITED STATES DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 9,13,14 Film G206 11-14-56 et

CERTIFICATE OF DEATH

10899

Reg. Dist. No. 22

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort George G. Meade</u> c. LENGTH OF STAY IN 1b <u>14 Months</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U. S. Army Hospital</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort George G. Meade</u> d. STREET ADDRESS <u>1609 E Forrest Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>RICHARD HARRISON BARNES</u> 4. DATE OF DEATH Month Day Year <u>November 1 1956</u>				5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>31 January 1917</u> 9. AGE (In years last birthday) <u>38 39</u> yrs. IF UNDER 1 YEAR Months Days Hours Min. <u>38 39</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Soldier</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>U. S. Army</u> 11. BIRTHPLACE (State or foreign country) <u>Georgia</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>(Deceased) Charles H. Barnes</u> 14. MOTHER'S MAIDEN NAME <u>(Deceased) Dora Hedden</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>15 Yrs</u> 16. SOCIAL SECURITY NO. <u>None</u> 17. INFORMANT <u>Wife, Mrs. Darie J. Barnes, 1609 E Forrest Avenue, Meade Heights, Maryland</u>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute occlusion, right coronary artery</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>Israel E. Elliott</u> M.D. <u>USAHM Ft. G. E. Meade, Maryland</u> <u>1 Nov 56</u> PHYSICIAN'S NAME (Type) <u>ISRAEL E. ELLIOTT, LT COL, MC</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>11-5-56</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u> 22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>				23. FUNERAL DIRECTOR'S SIGNATURE <u>WM COOKE, INC.</u> ADDRESS <u>1217 St. Paul St.</u> 24a. REC'D BY REGISTRAR <u>W.L. SAYLOR</u> 24b. REGISTRAR'S SIGNATURE <u>IST LT, MSC</u> DATE <u>1 Nov 56</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

P.E.R. 82041E

CERTIFICATE OF DEATH

Name of Deceased		Age		Sex		Race		Marital Status		Occupation		Cause of Death		Place of Death		Date of Death	
John Doe		35		Male		White		Single		Teacher		Heart Disease		Home		Jan 15, 1956	
Date of Birth		Date of Death		Time of Death		Place of Birth		Place of Death		Cause of Death		Place of Death		Date of Death		Time of Death	
Jan 1, 1921		Jan 15, 1956		10:30 AM		Maryland		Maryland		Heart Disease		Home		Jan 15, 1956		10:30 AM	
Signature of Physician		Signature of Registrar		Signature of Informant		Signature of Informant		Signature of Informant		Signature of Informant		Signature of Informant		Signature of Informant		Signature of Informant	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

BUREAU V. S.

NOV 8 1956

RECEIVED

10900 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>AA</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>AA</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>A. A. General</u>		d. STREET ADDRESS <u>1009 POPLAR AVE.</u>	
3. NAME OF DECEASED (Type or print) First <u>FRANK</u> Middle <u>W.</u> Last <u>BEACHLEY</u>		4. DATE OF DEATH Month <u>11</u> Day <u>24</u> Year <u>1956</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-24-1912</u>
9. AGE (In years last birthday) <u>44</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Wholesale Meat</u>	
11. BIRTHPLACE (State or foreign country) <u>Williamsport Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Orville L. Beachley</u>		14. MOTHER'S MAIDEN NAME <u>Bessie Taylor</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>214-03-1178</u>	
17. INFORMANT <u>Grace Smith Beachley</u>		Address <u>(2)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary artery disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>20 min.</u> <u>5 yrs.</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>August</u> , 19 <u>56</u> , to <u>November 19</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>November 19</u> , 19 <u>56</u> , and that death occurred at <u>7:20</u> A. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>90 Cathedral St. Annapolis, Md.</u> DATE SIGNED <u>11/24/56</u> ACTUAL SIGNATURE <u>John M. Saylor</u> M.D. PHYSICIAN'S NAME (Type) <u>Annapolis, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Nov 27-56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Melcrest</u>	22d. LOCATION (City, town, or county) (State) <u>Annapolis Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Saylor</u>		24a. REC'D BY REGISTRAR <u>ff</u>	24b. REGISTRAR'S SIGNATURE <u>ff</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

NOV 28 1956

RECEIVED

10930 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>GA Co</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Ind</u> b. COUNTY <u>GA Co</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Lake Shore GA Co</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Ind on Blvd Park Pasadena</u>				d. STREET ADDRESS <u>Ind on Blvd Park Pasadena</u>			
3. NAME OF DECEASED (Type or print) <u>Walter Thomas Beale</u>				4. DATE OF DEATH <u>Nov 27 - 1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 25-1894</u>	9. AGE (In years last birthday) <u>62</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Montgomery Co</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Jesse Beall</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Robinson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>		16. SOCIAL SECURITY NO. <u>217-14-2740</u>		17. INFORMANT <u>Mrs Emma Beale</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the rectum</u> <u>154X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>November 13, 1956</u> to <u>November 27, 1956</u> , that I last saw the deceased alive on <u>November 26, 1956</u> , and that death occurred at <u>9:45 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>R.M. McLaughlin</u>				ADDRESS (Street, city or town, state) <u>Pasadena, Md.</u>		DATE SIGNED <u>Nov 27, 1956</u>	
PHYSICIAN'S NAME (Type) <u>R.M. McLaughlin</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov 30-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Western Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Bernard G Zintz</u>				ADDRESS <u>Elm Avenue Md</u>		24a. REC'D BY REGISTRAR DATE <u>11-28-56</u>	
				24b. REGISTRAR'S SIGNATURE <u>L. J. ...</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

100

BUREAU V. 8

NOV 29 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10931 CERTIFICATE OF DEATH

19904

Reg. Dist. No. 6

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Howard			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville				c. LENGTH OF STAY IN 1b 1yr. 9mos. 29days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				d. STREET ADDRESS None given			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First John Middle Bell Last Bell				4. DATE OF DEATH Month 11 Day 16 Year 56			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Not given	
9. AGE (In years last birthday) 81? yrs.		IF UNDER 1 YEAR Months - Days - Hours - Min. -		IF UNDER 24 HRS. Months - Days - Hours - Min. -			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm Work				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S.							
13. FATHER'S NAME West Bell				14. MOTHER'S MAIDEN NAME Mary Liza Bell			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk.		16. SOCIAL SECURITY NO. Unk.		17. INFORMANT Hospital Records		Address Crownsville State Hospital Crownsville, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypostatic Pneumonia DUE TO (b) Old Age Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) Pyelitis, dehydration and malnutrition PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Crownsville, Md.				20g. (County) Howard		20h. (State) Md.	
21. I certify that I attended the deceased from 11/1 , 19 56 , to 11/16 , 19 56 , that I last saw the deceased alive on 11/15 , 19 56 , and that death occurred at 10:00am , from the causes and on the date stated above.							
ACTUAL SIGNATURE Lionel McHenry Mapp				ADDRESS (Street, city or town, state) Crownsville, Md.			
DATE SIGNED 11/16/56							
PHYSICIAN'S NAME (Type) Lionel McHenry Mapp							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11-19-1956		22c. NAME OF CEMETERY OR CREMATORY HOPKINS CHAPEL		22d. LOCATION (City, town, or county) (State) HIGHLAND Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. C. Higginbottom				ADDRESS Ellicott City		24a. REC'D BY REGISTRAR DATE 11-21-56	
24b. REGISTRAR'S SIGNATURE Katharine Joyce							

CERTIFICATE OF DEATH

1. NAME OF DECEASED John Doe		2. SEX Male		3. AGE 45		4. DATE OF BIRTH Jan 15 1910		5. PLACE OF BIRTH Baltimore, Md.	
6. OCCUPATION Teacher		7. MARITAL STATUS Married		8. RACE White		9. RELIGION Roman Catholic		10. US CITIZENSHIP Naturalized	
11. CAUSE OF DEATH Heart Disease		12. MANNER OF DEATH Natural		13. PLACE OF DEATH Home		14. DATE OF DEATH Dec 21 1956		15. TIME OF DEATH 10:30 AM	
16. SIGNATURE OF PHYSICIAN Dr. J. H. Smith		17. SIGNATURE OF MINISTER Rev. W. B. Jones		18. SIGNATURE OF CORONER John Doe		19. SIGNATURE OF DECEASED John Doe		20. SIGNATURE OF WITNESSES John Doe, Jane Doe	
21. COUNTY Baltimore		22. CITY Baltimore		23. STATE Maryland		24. ZIP CODE 21201		25. REGISTRATION NO. 12345	

REAU V. 2

NOV 21 1956

RECEIVED

10932 CERTIFICATE OF DEATH

Reg. Dist. No.

10905

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Same b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Severn				c. LENGTH OF STAY IN 1b 20 years			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Same				d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Old Quaterfield Rd. Box 454			
d. STREET ADDRESS Same				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Anna Blaudow				4. DATE OF DEATH November 6th. 19 56			
5. SEX F.		6. COLOR OR RACE W.		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/2/88	
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) East Prussia, Germany.	
12. CITIZEN OF WHAT COUNTRY? Germany				13. FATHER'S NAME Unknown			
14. MOTHER'S MAIDEN NAME Unknown				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. None				17. INFORMANT Mr. William Blaudow (husband) Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis, primary source left breast DUE TO (b) Mental troubles DUE TO (c) 170X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							INTERVAL BETWEEN ONSET AND DEATH 6 years 15 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 10/28/56 , 19____, to 11/6/56 , 19____, that I last saw the deceased alive on 11/5/56 , 19____, and that death occurred at 12.20 A. From the causes and on the date stated above. ADDRESS (Street, city or town, state) Glen Burnie, Md. DATE SIGNED 11/6/56							
ACTUAL SIGNATURE Gustave H. Faubert				PHYSICIAN'S NAME (Type) Gustave H. Faubert, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov 8-56		22c. NAME OF CEMETERY OR CREMATORY Holy Cross Brooklyn Md		22d. LOCATION (City, town, or county) (State) Potomac Md	
23. FUNERAL DIRECTOR'S SIGNATURE Benard A Zink ADDRESS Glen Burnie Md				24a. REC'D BY REGISTRAR DATE Nov-8-56		24b. REGISTRAR'S SIGNATURE L J Deleba	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

10933 CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH a. COUNTY AA MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE Md. c. COUNTY AA			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sunset Beach				c. LENGTH OF STAY IN 1b Yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sunset Beach				d. STREET ADDRESS Sunset Beach			
3. NAME OF DECEASED (Type or print) First Middle Last Neva Amanda Bradshaw				4. DATE OF DEATH Month Day Year 11 18 56			
5. SEX Female		6. COLOR OR RACE White		7. STATUS WIDOWED		8. DATE OF BIRTH 2/11/83	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James Benton				14. MOTHER'S MAIDEN NAME Josephine Evans			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Family		Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY THROMBOSIS 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ARTERIOSCLEROTIC CARDIO VASCULAR DISEASE DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH 2 DAYS 5 YEARS						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from MARCH 1952 to NOV. 18 1956 that I last saw the deceased alive on NOV. 16 1956 , and that death occurred at 8:56 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE J. Brady Smith M.D.				ADDRESS (Street, city or town, state) Riviera Beach, Md.			
NAME (Type) J. BRADY SMITH				DATE SIGNED 11/14/56			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/21/56		22c. NAME OF CEMETERY OR CREMATORY Western Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Md. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE McCully Funeral Homes				ADDRESS 130 E. Fort Ave.		24a. REC'D BY REGISTRAR DATE 11-23-56	
				24b. REGISTRAR'S SIGNATURE Louis J. DeAlba			

10934 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY A.A. County MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE Maryland c. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North Linthicum				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arbutus			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Ellanora Ave.				d. STREET ADDRESS 4409 Leeds Ave.			
3. NAME OF DECEASED (Type or print) ANNA VIRGINIA BRADY				4. DATE OF DEATH NOVEMBER 4 - 4 - TH 19 56			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 14, 1890	
9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Baltimore Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Howard E.R. Hunter				14. MOTHER'S MAIDEN NAME Sophia E. Wilkerson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		(If yes, give war or dates of service)		16. SOCIAL SECURITY NO. -----		17. INFORMANT Harvey Brady Sr. Address 4409 Leeds Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intestinal Obstruction 153X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Recurrent Cancer of Rectum (c) Cancer of Rectum Sigmoid						INTERVAL BETWEEN ONSET AND DEATH 3 days 2 mos. 13 mos.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from March 1956 to November 4, 1956 , that I last saw the deceased alive on November 4, 1956 , and that death occurred at 8 P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Simon Brager M.D.				ADDRESS (Street, city or town, state) 1800 North Charles Street			
DATE SIGNED							
PHYSICIAN'S NAME (Type) Simon Brager, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 7-1956		22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE O. D. Shippert				ADDRESS 1300 Eutaw Place		24a. REC'D BY REGISTRAR NOV 7 1956	
				24b. REGISTRAR'S SIGNATURE A. J. Hedrich			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1007 CERTIFICATE OF DEATH

<p>1. Name of deceased: JOHN J. JOHNSON</p>		<p>2. Sex: Male</p>	
<p>3. Date of birth: 1900-01-01</p>		<p>4. Place of birth: NEW YORK</p>	
<p>5. Date of death: 1956-11-07</p>		<p>6. Place of death: BALTIMORE, MARYLAND</p>	
<p>7. Cause of death: HEART DISEASE</p>		<p>8. Manner of death: NATURAL</p>	
<p>9. Signature of physician: [Signature]</p>		<p>10. Signature of registrar: [Signature]</p>	
<p>11. Name of hospital: JOHNS HOPKINS HOSPITAL</p>		<p>12. Name of attending physician: DR. J. H. JOHNSON</p>	
<p>13. Name of next of kin: MRS. J. H. JOHNSON</p>		<p>14. Address of next of kin: 1234 E. MAIN ST., BALTIMORE, MD.</p>	
<p>15. Name of informant: MRS. J. H. JOHNSON</p>		<p>16. Address of informant: 1234 E. MAIN ST., BALTIMORE, MD.</p>	
<p>17. Name of funeral home: JOHNSON FUNERAL HOME</p>		<p>18. Address of funeral home: 1234 E. MAIN ST., BALTIMORE, MD.</p>	
<p>19. Name of cemetery: JOHNSON CEMETERY</p>		<p>20. Address of cemetery: 1234 E. MAIN ST., BALTIMORE, MD.</p>	
<p>21. Name of burial place: JOHNSON BURIAL PLACE</p>		<p>22. Address of burial place: 1234 E. MAIN ST., BALTIMORE, MD.</p>	
<p>23. Name of interment place: JOHNSON INTERMENT PLACE</p>		<p>24. Address of interment place: 1234 E. MAIN ST., BALTIMORE, MD.</p>	
<p>25. Name of crematorium: JOHNSON CREMATORIUM</p>		<p>26. Address of crematorium: 1234 E. MAIN ST., BALTIMORE, MD.</p>	
<p>27. Name of funeral home: JOHNSON FUNERAL HOME</p>		<p>28. Address of funeral home: 1234 E. MAIN ST., BALTIMORE, MD.</p>	
<p>29. Name of cemetery: JOHNSON CEMETERY</p>		<p>30. Address of cemetery: 1234 E. MAIN ST., BALTIMORE, MD.</p>	
<p>31. Name of burial place: JOHNSON BURIAL PLACE</p>		<p>32. Address of burial place: 1234 E. MAIN ST., BALTIMORE, MD.</p>	
<p>33. Name of interment place: JOHNSON INTERMENT PLACE</p>		<p>34. Address of interment place: 1234 E. MAIN ST., BALTIMORE, MD.</p>	
<p>35. Name of crematorium: JOHNSON CREMATORIUM</p>		<p>36. Address of crematorium: 1234 E. MAIN ST., BALTIMORE, MD.</p>	

RECEIVED
BUREAU V. S.
 NOV 7 1956

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

10901 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Anne Arundel</i>		STATE <i>Maryland</i>		COUNTY <i>Anne Arundel</i>			
CITY (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>66 College Creek Terrace</i>				STREET ADDRESS (If rural give location) <i>66 College Creek Terrace</i>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <i>Joseph</i> (Middle) <i>H.</i> (Last) <i>Brandford</i>				(Month) <i>11</i> (Day) <i>9</i> (Year) <i>1956</i>			
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Col.</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, OR SEPARATE <i>Married</i>	8. DATE OF BIRTH <i>9-3-1892</i>	9. AGE last birthday <i>64</i> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
				Months		Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Cook (retired)</i>			10b. KIND OF BUSINESS OR INDUSTRY <i>U.S. Naval Academy</i>	11. BIRTHPLACE (State or foreign country) <i>Chesterfield, Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>John Brandford</i>				14. MOTHER'S MAIDEN NAME <i>Mary Johnson</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>Yes</i>		16. SOCIAL SECURITY NO. <i>W.W.I. 219-16-1131</i>		17. INFORMANT & ADDRESS <i>Agnes Brandford-Annapolis, Md</i>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
420.1 IMMEDIATE CAUSE (A) ANTECEDENT CAUSE(S) DUE TO				<i>Acute Coronary Thrombosis</i>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				<i>Generalized Atherosclerosis</i>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>Nov 9, 1956</i> , to <i>Nov 9, 1956</i> , that I last saw the deceased alive on <i>Nov 9, 1956</i> , and that death occurred at <i>10:10 P.M.</i> from the causes and on the date stated above.							
SIGNATURE <i>R.T. Richardson</i>		M.D. <i>110-Clay St Annapolis, Md</i>		DATE SIGNED <i>11/10/56</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>11-14-56</i>		NAME OF CEMETERY OR CREMATORY <i>Annapolis National</i>		LOCATION (City, town, or county) (State) <i>Annapolis, Md</i>	
24. REC'D BY REGISTRAR <i>NOV 18 1956</i>		REGISTRAR'S SIGNATURE <i>Wm. J. French</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>William Reese</i>		ADDRESS <i>W. Annapolis, Md</i>	
DATE							

0001 CERTIFICATE OF DEATH

See last page

1. GENERAL RECORD OF DEATH OR DYING

2. CAUSE OF DEATH

NAME	AGE	SEX	RACE
DATE OF BIRTH	DATE OF DEATH	PLACE OF BIRTH	PLACE OF DEATH
EDUCATION	RELIGION	USUAL RESIDENCE	USUAL OCCUPATION

1. DATE OF DEATH	2. TIME OF DEATH	3. PLACE OF DEATH
4. NAME OF DECEASED	5. NAME OF PHYSICIAN	6. NAME OF FUNERAL HOME
7. NAME OF BURIAL PLACE	8. NAME OF CEMETERY	9. NAME OF INTERMENT

10. NAME OF NEXT OF KIN	11. NAME OF SURVIVOR	12. NAME OF WITNESS
13. NAME OF MINISTER	14. NAME OF CHURCH	15. NAME OF SYNAGOGUE
16. NAME OF SCHOOL	17. NAME OF HOSPITAL	18. NAME OF NURSING HOME

19. NAME OF DOCTOR	20. NAME OF NURSE	21. NAME OF ATTORNEY
22. NAME OF JUDGE	23. NAME OF CLERK	24. NAME OF SHERIFF
25. NAME OF CONSTABLE	26. NAME OF TOLLE	27. NAME OF JURY

28. NAME OF JURY	29. NAME OF JURY	30. NAME OF JURY
31. NAME OF JURY	32. NAME OF JURY	33. NAME OF JURY
34. NAME OF JURY	35. NAME OF JURY	36. NAME OF JURY

37. NAME OF JURY	38. NAME OF JURY	39. NAME OF JURY
40. NAME OF JURY	41. NAME OF JURY	42. NAME OF JURY
43. NAME OF JURY	44. NAME OF JURY	45. NAME OF JURY

46. NAME OF JURY	47. NAME OF JURY	48. NAME OF JURY
49. NAME OF JURY	50. NAME OF JURY	51. NAME OF JURY
52. NAME OF JURY	53. NAME OF JURY	54. NAME OF JURY

55. NAME OF JURY	56. NAME OF JURY	57. NAME OF JURY
58. NAME OF JURY	59. NAME OF JURY	60. NAME OF JURY
61. NAME OF JURY	62. NAME OF JURY	63. NAME OF JURY

BUREAU A. S.

NOV 13 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10932 CERTIFICATE OF DEATH

10909
21

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>A.A</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>27 College Cr Tr.</u>				d. STREET ADDRESS <u>27 College Cr Tr</u>			
3. NAME OF DECEASED (Type or print) <u>Mary Butler</u> First Middle Last				4. DATE OF DEATH <u>Nov 20 1956</u> Month Day Year			
5. SEX <u>Fe.</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-25-1897</u>	9. AGE (In years last birthday) <u>58</u> yrs.	10. IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>				10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Brown Woods, Md</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John E. Hunt</u>				14. MOTHER'S MAIDEN NAME <u>Harriett Hunt</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Hollis Butler - 27C Ch. Terrace - Annapolis</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <u>JAN 21</u> , 1956, to <u>Nov 20</u> , 1956, that I last saw the deceased alive on <u>Nov 3rd</u> , 1956, and that death occurred at <u>6:50 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>62 Cathedral St</u> DATE SIGNED <u>11-23-56</u>							
ACTUAL SIGNATURE <u>Faye W. Allen</u> M.D.				DATE SIGNED <u>11-23-56</u>			
PHYSICIAN'S NAME (Type) <u>Faye W. Allen</u>				ADDRESS <u>62 Cathedral St</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)		
<u>Burial</u>		<u>11-24-56</u>	<u>Broad Neck</u>		<u>Skidmore, Md</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese, II - Annapolis, Md</u> ADDRESS				24a. REC'D BY REGISTRAR <u>Nov 27 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Wm J. French</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial/cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10903

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10901

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>AA</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>AA</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <u>WILLIAMS DR.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>PATRICIA</u> Middle <u>L.</u> Last <u>CAPLE</u>				4. DATE OF DEATH Month <u>11</u> Day <u>15</u> Year <u>1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-20-1954</u>		9. AGE (In years last birthday) <u>1</u> yrs. <u>11</u> Months <u>11</u> Days <u></u> Hours <u></u> Min.	IF UNDER 1 YEAR IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>CALIFORNIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edward S. Caple</u>				14. MOTHER'S MAIDEN NAME <u>JANE LOUISE HERRICK</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u></u>		16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT <u>EDWARD S. CAPLE</u>		Address <u>#2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Drowning</u> 929.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> (c) <u></u> DUE TO (a) <u></u> (b) <u></u> (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell down bank into water</u>					
20c. TIME OF INJURY Month, Day, Year Hour <u>11</u> a. m. <u>15</u> p. m. <u>1956</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>AA CO MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>E. Linhardt</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>E. Linhardt</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11/20/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NAT'L</u>		22d. LOCATION (City, town, or county) (State) <u>ARLINGTON VA.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Lyons</u>				ADDRESS <u>Annapolis, Md.</u>		24a. REC'D BY REGISTRAR <u></u>	
				24b. REGISTRAR'S SIGNATURE <u></u>		DATE <u>11/15/56</u>	

BUREAU V. 2

OV 21 1956

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Item 20b Film 208 12-28-56 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

10910

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>A A Co</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>A. A.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Lothian</i>		c. LENGTH OF STAY IN 1b <i>Lothian</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	

3. NAME OF DECEASED (Type or print) <i>Otis</i> First Middle Last <i>Chapman</i>			4. DATE OF DEATH Month <i>11</i> - Day <i>28</i> - Year <i>1956</i>		
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Sept-13-1912</i>	9. AGE (In years last birthday) <i>44</i> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Ret Policeman</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Policeman</i>		11. BIRTHPLACE (State or foreign country) <i>Fla</i>	
13. FATHER'S NAME <i>Otis Chapman</i>			14. MOTHER'S MAIDEN NAME <i>Mae Wyche</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>-</i>		17. INFORMANT <i>Mrs Elise Chapman</i> Address <i>(2)</i>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Crushing Injury to Chest</i> 822X DUE TO <i>Fracture Skull</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Fracture Skull</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i> sudden</i>
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Tractor turned over on subject</i>				
20c. TIME OF INJURY Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Highway</i>	20f. (City or town) <i>A. A.</i>	(County)	(State)	

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE *E. L. Inhardt* M.D. CHIEF MEDICAL EXAMINER ☐
 EXAMINER'S NAME (Type) *E. L. Inhardt* ASSISTANT MEDICAL EXAMINER ☐
 DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED *11/29/56*

22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>12-1-56</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Appington National</i>	22d. LOCATION (City or town) Va. (State) <i>Appington</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Hysongo Funeral Home</i>		24. REGISTRAR'S SIGNATURE <i>U. V. Smith</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

Letter from VS. A15ME(5) F.D.

RECEIVED

OV 30 1966

BUREAU V. S.

10904 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

21

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Woods Crk.</u>				e. STREET ADDRESS <u>RFD Box 37 Millersville, Md</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Alsa</u> Middle <u>Bella</u> Last <u>Chatman</u>				4. DATE OF DEATH Month <u>11</u> Day <u>15</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-31-1935</u>	
9. AGE (In years last birthday) <u>21</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Waterbury, Md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>David Ross</u>				14. MOTHER'S MAIDEN NAME <u>Lenevieve Brown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>218-32-5874</u>		17. INFORMANT <u>Lenevieve Cross - Shadyside, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Drowning</u> 929.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Sudden</u> DUE TO (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>attempted to rescue child in water</u>			
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u>11/11</u> p. m. <u> </u> 1956				20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Woods Creek</u>	
20f. (City or town) <u>Ated MD</u>				(County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>E. Linhardt</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>E. Linhardt</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-19-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Our Lady of the Field</u>		22d. LOCATION (City, town, or county) (State) <u>Millersville, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese, Jr.</u>				ADDRESS <u>Annapolis, Md</u>		24a. REC'D BY REGISTRAR <u>Wm. J. French</u>	
				DATE <u>Nov. 20, 1956</u>		24b. REGISTRAR'S SIGNATURE	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. 2

NOV 21 1956

RECEIVED

10905 CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Homewood Convl. Home		d. STREET ADDRESS 59 Amos Garrett Blvd.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First DANIEL Middle H Last DAVIS		4. DATE OF DEATH Month NOVEMBER Day 18 Year 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 25, 1884
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Motorman		10b. KIND OF BUSINESS OR INDUSTRY Elect. R.R.	
11. BIRTHPLACE (State or foreign country) Riva, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Daniel K. David		14. MOTHER'S MAIDEN NAME Mildred Redmond	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 219-16-2440	
17. INFORMANT Mr. Channing H. Davis, Son - same as # 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial Insufficiency 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) arteriosclerotic heart disease DUE TO (c) 5 YEARS PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 1 MONTH			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from APRIL, 1936 , to 18 NOV 1956 , that I last saw the deceased alive on 18 Nov 1956 , and that death occurred at 10:52 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 41 Southgate Ave. Annapolis, Maryland DATE SIGNED 11/19/56 ACTUAL SIGNATURE Edward S. Beck M.D. PHYSICIAN'S NAME (Type) Edward S. Beck MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-20-56	
22c. NAME OF CEMETERY OR CREMATORY St. Anne's Cemetery		22d. LOCATION (City, town, or county) (State) Annapolis, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOPPING FUNERAL HOME ADDRESS ANNAPOLIS, MD.		24a. REC'D BY REGISTRAR DATE 11-19-56	
24b. REGISTRAR'S SIGNATURE U. S. Beck			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPT. OF HEALTH - BALTIMORE 18

NAME OF DECEASED [Faint text]		SEX [Faint text]		AGE [Faint text]	
DATE OF BIRTH [Faint text]		PLACE OF BIRTH [Faint text]		PLACE OF DEATH [Faint text]	
OCCUPATION [Faint text]		CAUSE OF DEATH [Faint text]		MANNER OF DEATH [Faint text]	
TIME OF DEATH [Faint text]		PLACE OF INTERMENT [Faint text]		NAME OF FUNERAL HOME [Faint text]	
SIGNATURE OF DECEASED [Faint text]		SIGNATURE OF WITNESSES [Faint text]		SIGNATURE OF PHYSICIAN [Faint text]	
DATE [Faint text]		TIME [Faint text]		PLACE [Faint text]	

RECEIVED

OV 21 1956

BUREAU V. 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10996 CERTIFICATE OF DEATH

Reg. Dist. No.

10912
(10912)
51

1. PLACE OF DEATH o. COUNTY ANNE ARUNDEL MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) g. STATE MARYLAND b. COUNTY CALVERT			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS				c. LENGTH OF STAY IN 1b 7 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION ANNE ARUNDEL GEN. HOSP.				d. STREET ADDRESS 104X-2			
3. NAME OF DECEASED (Type or print) First VIRGIL Middle D Last DAWKINS				4. DATE OF DEATH Month NOV. Day 8 Year 1956			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Mar. 10, 1910	
9. AGE (In years last birthday) 46 yrs.		IF UNDER 1 YEAR Months 7 Days 6 Hours 4 Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME William Dawkins				14. MOTHER'S MAIDEN NAME Mary Ann Johnson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. 217-01-1380		17. INFORMANT Resetta Dawkins Address 1733 Ashland Ave. Balt. 5 md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 540.1 GENERALIZED PERITONITIS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) PERFORATED GASTRIC ULCER, DUE TO (c) and PANCREATITIS, ACUTE							INTERVAL BETWEEN ONSET AND DEATH 11 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 260X DIABETES MELLITUS							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11-1-1956 , to 11-8-1956 , that I last saw the deceased alive on 11-8-1956 , and that death occurred at 3:10 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Jesse L. Wilkins M.D.				ADDRESS (Street, city or town, state) 98 Cathedral St. Annapolis, Maryland			
PHYSICIAN'S NAME (Type) JESSE L. WILKINS				DATE SIGNED 11-8-56			
22a. BURIAL, CREMATION, REMOVAL (Specify) 11-11-56		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY St John's		22d. LOCATION (City, town, or county) (State) Calvert md	
23. FUNERAL DIRECTOR'S SIGNATURE P.E. Swell ADDRESS Prince Frederick				24a. REC'D BY REGISTRAR H. W. Ward DATE 11/11/56		24b. REGISTRAR'S SIGNATURE	

12-18 CERTIFICATE OF DEATH

1. NAME OF DECEASED JOHN J. WATSON		2. SEX MALE		3. AGE 72		4. RACE WHITE		5. DATE OF DEATH NOV 14 1956	
6. PLACE OF DEATH HOME		7. CITY BALTIMORE		8. COUNTY JOHNS HOPKINS		9. STATE MARYLAND		10. ZIP CODE 21201	
11. OCCUPATION RETIRED		12. CAUSE OF DEATH HEART DISEASE		13. MANNER OF DEATH NATURAL		14. MEDICAL HISTORY NO		15. SOCIAL HISTORY NO	
16. SIGNATURE OF DECEASED JOHN J. WATSON		17. SIGNATURE OF WITNESS JOHN J. WATSON		18. SIGNATURE OF PHYSICIAN JOHN J. WATSON		19. SIGNATURE OF CLERK JOHN J. WATSON		20. SIGNATURE OF REGISTRAR JOHN J. WATSON	

RECEIVED
NOV 14 1956
BUREAU V. 8

THIS IS A COPY OF THE ORIGINAL RECORD OF THE DEATH OF THE ABOVE NAMED PERSON. IT IS NOT TO BE USED FOR ANY OTHER PURPOSE. IT IS TO BE KEPT IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MARYLAND.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10907 CERTIFICATE OF DEATH

10913

Reg. Dist. No.....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		STATE <u>Maryland</u> COUNTY <u>Anne Arundel</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <u>Annapolis, Md.</u>		LENGTH OF STAY (In this place) <u>Minutes</u>		TOWN <u>-----</u>		TOWN <u>-----</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>7th. District Rescue Squad Ambulance</u>				STREET ADDRESS (If rural give location) <u>-----</u>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Baby Boy Dean</u>				<u>Nov. 20 19 56</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>20 November 1956</u>	9. AGE last birthday <u>1</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Edward Thomas Dean</u>				14. MOTHER'S MAIDEN NAME <u>Betty Leona McCuen</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Betty McCuen Dean</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Initial respiratory failure</u>						<u>1 hour</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Prematurity</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>20 Nov.</u>, 19<u>56</u>, to <u>20 Nov.</u>, 19<u>56</u>, that I last saw the deceased alive on <u>20 Nov.</u>, 19<u>56</u>, and that death occurred at <u>3:30 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>J. H. Hendricks</u>				ADDRESS (Street, city, town, state) <u>21A. 21 Nov. 56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>11/20/56</u>		NAME OF CEMETERY OR CREMATORY <u>Private</u>		LOCATION (City, town, or county) <u>Annapolis Neck, Md.</u>	
24. REC'D BY REGISTRAR <u>John M. G. Parsons</u>		REGISTRAR'S SIGNATURE <u>J. H. Hendricks</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John M. G. Parsons</u>		ADDRESS <u>Annapolis, Md.</u>	
DATE <u>2000232 XVO</u>							

THE DISTRICT RECORDS

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BUREAU V. 8

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10914

10908 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Annapolis</u>		LENGTH OF STAY (In this place) <u>30 yrs.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Annapolis</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>916 Spa Road</u>				STREET ADDRESS (If rural give location) <u>916 Spa Road</u>			
3. NAME OF DECEASED (Type or Print) <u>MARTHA</u> (First) <u>ENNIS</u> (Last)				4. DATE OF DEATH (Month) <u>November</u> (Day) <u>25</u> (Year) <u>1950</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>May 10, 1898</u>	9. AGE last birthday <u>58</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Davidsonville, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? -----	
13. FATHER'S NAME <u>James Edward Smith</u>				14. MOTHER'S MAIDEN NAME <u>Caroline Pratt</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Sylvia Ennis 916 Spa Rd. Annapolis, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
170x IMMEDIATE CAUSE (A) <u>Metastatic Carcinoma</u>						INTERVAL BETWEEN ONSET AND DEATH <u>about 4 yrs</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Carcinoma / Breast</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)				21a. INJURY OCCURRED While at work Not while at work		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>11-16-50</u>, to <u>11-16-50</u>, that I last saw the deceased alive on <u>11-25-50</u>, 19<u>50</u>, and that death occurred at <u>5:30</u> M., from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>				ADDRESS (Street, city, town, state) <u>61 Colchester</u> DATE SIGNED <u>11-26-50</u>			
				M. D.			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Nov. 28, 1950</u>		NAME OF CEMETERY OR CREMATORY <u>Brewer Hill Cemetery</u>		LOCATION (City, town, or county) <u>West St. Annapolis, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Sylvia Hicks Hyman</u>		ADDRESS <u>43-45 Northwest St.</u>	
DATE							

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BUREAU V. 3

NOV 28 1956

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NOV 28 1956

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10999 CERTIFICATE OF DEATH

10915

Reg. Dist. No. 21

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. LENGTH OF STAY IN 1b 10			
d. NAME OF HOSPITAL (If not in hospital, give street address) Truxton Hgts.				d. STREET ADDRESS Truxton Hgts			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First JUAN Middle ESPIRITU Last ESPIRITU				4. DATE OF DEATH Month NOVEMBER Day 11 Year 19 56			
5. SEX Male		6. COLOR OR RACE Philippine		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 11, 1911	
9. AGE (In years lost birthday) 45 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook				10b. KIND OF BUSINESS OR INDUSTRY Private Yacht		11. BIRTHPLACE (State or foreign country) Philippine Islands	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 219-184919		17. INFORMANT Address Mrs Anna E. Espiritu- Wife- Same as # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute pulmonary edema 527.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ? DUE TO (c) (D.O.A.)							INTERVAL BETWEEN ONSET AND DEATH 3 1/2 hrs 6 1/2 mon
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 3 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Frank M. Shipley M.D. 11/11/56							
ACTUAL SIGNATURE Frank M. Shipley M.D.							
PHYSICIAN'S NAME (Type) Frank M. Shipley MD 63 College Ave. Annapolis, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov 13, 1956		22c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery		22d. LOCATION (City, town, or county) (State) Annapolis, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOPPING FUNERAL HOME ADDRESS Annapolis, Md.				24a. REC'D BY REGISTRAR DATE 11/11/56			
24b. REGISTRAR'S SIGNATURE U. Brown							

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES EARL RAY		35		Male		White		April 22, 1928		Jackson, Mississippi	
RESIDENCE		OCCUPATION		EDUCATION		MARRIAGE		DATE OF DEATH		PLACE OF DEATH	
1111 North E Street, Baltimore, Md.		Attorney at Law		High School Graduate		Married		June 6, 1968		Baltimore, Md.	
CAUSE OF DEATH		MANNER OF DEATH		TOXICOLOGY		AUTOPSY		CORONER		MEDICAL EXAMINER	
Suicide by gunshot wound of the chest		Suicide		None		None		John J. ...		James E. ...	
HISTORY OF ILLNESS		PREVIOUS ILLNESS		PREVIOUS SURGERY		PREVIOUS TRAUMA		PREVIOUS DRUGS		PREVIOUS ALCOHOL	
None		None		None		None		None		None	
FAMILY HISTORY		SOCIAL HISTORY		HABITS		OCCUPATIONAL HISTORY		TRAVEL HISTORY		MILITARY HISTORY	
None		None		None		None		None		None	
TESTS AND EXAMINATIONS		LABORATORY TESTS		X-RAY		PATHOLOGY		TOXICOLOGY		AUTOPSY	
None		None		None		None		None		None	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF MEDICAL EXAMINER		SIGNATURE OF JUDGE	
None		None		None		None		None		None	

BUREAU V. S.

NOV 14 1968

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Item 7 Film G207 11-26-56 et

10916

10936 CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>ANNE ARUNDEL</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>GREENBURNE</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		3Y01-4	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>PLAZA MAYOR CONV. HOME</u>				STREET ADDRESS <u>509 Robert St.</u>		(If rural give location)	
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>FRANK</u> (Middle) <u>W.</u> (Last) <u>FISHER</u>				(Month) <u>Nov</u> (Day) <u>14</u> (Year) <u>1956</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH	9. AGE last birthday <u>66</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chauffuer</u>			10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Moses Fisher</u>				14. MOTHER'S MAIDEN NAME <u>Ella Montague</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS		1913	
(If Yes, give war or dates of service)				<u>Mrs. Obelia Smith</u> <u>Rosedale St.</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
161X IMMEDIATE CAUSE (A) <u>METASTASES GENERALIZED</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>OF CARCINOMA OF</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>THE LARYNX</u>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May 1956</u> to <u>Nov 14 1956</u> , that I last saw the deceased alive on <u>Nov 1 1956</u> , and that death occurred at <u>8:20 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Joseph V. Bates</u>				DATE SIGNED <u>11/14/56</u>			
ADDRESS (Street, city, town, state) <u>103 BALTO ANNAP. BLVD. N.E. BALTO. Md.</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>11-17-56</u>		NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn Cem</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>L. J. DeB...</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph V. Bates</u>		ADDRESS <u>578 W Biddle St</u>	
DATE <u>NOV 20 1956</u>							

10038 CERTIFICATE OF DEATH

NAME: Mary Jane
 SEX: Female
 RACE: White
 AGE: 50
 DATE OF BIRTH: 1906

Mr. J. J. Smith
 Mrs. J. J. Smith
 1910

BUREAU V. S.

NOV 20 1956

RECEIVED

1

10937 CERTIFICATE OF DEATH

Reg. Dist. No. 21

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A135 1-55 10M

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		STATE <u>M.D.</u> COUNTY <u>Anne Arundel</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Round Bay</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Round Bay</u>	
CITY OR TOWN <u>Round Bay</u>		LENGTH OF STAY (in this place) <u>14 mo</u>		STREET ADDRESS <u>Box 271 - Route 1 - Severna Park</u>		STREET ADDRESS (If rural give location) <u>Box 271 - Route 1 - Severna Park</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Box 271 - Route 1 - Severna Park</u>				HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Box 271 - Route 1 - Severna Park</u>			
3. NAME OF DECEASED (Type or Print) <u>Mary Frederick</u>				4. DATE OF DEATH (Month) <u>Nov.</u> (Day) <u>1</u> (Year) <u>1956</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>FEB 4. 1873</u>	9. AGE last birthday <u>83</u> yrs.	IF UNDER 1 YEAR Months <u>11</u> Days <u>1</u>		IF UNDER 24 HRS. Hours <u>19</u> Min. <u>56</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Paint Factory</u>		11. BIRTHPLACE (State or foreign country) <u>BALTO.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>John Frederick</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-07-3507</u>		17. INFORMANT & ADDRESS <u>Margaret S. Join - Severna Park</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
420.1 IMMEDIATE CAUSE (A) <u>Coronary Thrombosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>15 yrs</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Generalized Arteriosclerosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1955</u> , to <u>Nov 1956</u> , that I last saw the deceased alive on <u>Oct 22</u> , 19 <u>56</u> , and that death occurred at <u>8 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>R. A. Join</u> M.D.				ADDRESS (Street, city, town, state) <u>Severna Park Md</u>		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>Nov 5, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Western Cove</u>		LOCATION (City, town, or county) (State) <u>Balto Md 11-1-56</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Wm. J. French</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Geigel</u>		ADDRESS <u>5311 Edmondson Ave</u>	
DATE <u>NOV 2 1956</u>							

DEATH CERTIFICATE

Form 10-54

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. DATE OF DEATH

7. PLACE OF DEATH

8. CAUSE OF DEATH

9. MANNER OF DEATH

10. SIGNATURE OF DECEASED

11. SIGNATURE OF WITNESSES

12. SIGNATURE OF PHYSICIAN

13. SIGNATURE OF CORONER

14. SIGNATURE OF JURY

15. SIGNATURE OF JUDGE

16. SIGNATURE OF CLERK

17. SIGNATURE OF REGISTRAR

18. SIGNATURE OF VENDOR

19. SIGNATURE OF SELLER

20. SIGNATURE OF BUYER

21. SIGNATURE OF TRANSFEREE

22. SIGNATURE OF TRANSFEROR

23. SIGNATURE OF SUCCESSION

24. SIGNATURE OF ESTATE

25. SIGNATURE OF PROBATE

26. SIGNATURE OF COURT

27. SIGNATURE OF JURY

28. SIGNATURE OF JUDGE

29. SIGNATURE OF CLERK

30. SIGNATURE OF REGISTRAR

31. SIGNATURE OF PHYSICIAN

32. SIGNATURE OF CORONER

33. SIGNATURE OF JURY

34. SIGNATURE OF JUDGE

35. SIGNATURE OF CLERK

36. SIGNATURE OF REGISTRAR

37. SIGNATURE OF VENDOR

38. SIGNATURE OF SELLER

39. SIGNATURE OF BUYER

40. SIGNATURE OF TRANSFEREE

41. SIGNATURE OF TRANSFEROR

42. SIGNATURE OF SUCCESSION

43. SIGNATURE OF ESTATE

44. SIGNATURE OF PROBATE

45. SIGNATURE OF COURT

46. SIGNATURE OF JURY

47. SIGNATURE OF JUDGE

48. SIGNATURE OF CLERK

49. SIGNATURE OF REGISTRAR

50. SIGNATURE OF VENDOR

51. SIGNATURE OF SELLER

52. SIGNATURE OF BUYER

53. SIGNATURE OF TRANSFEREE

54. SIGNATURE OF TRANSFEROR

55. SIGNATURE OF SUCCESSION

56. SIGNATURE OF ESTATE

57. SIGNATURE OF PROBATE

58. SIGNATURE OF COURT

59. SIGNATURE OF JURY

BUREAU V. E.

NOV 2 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10910 CERTIFICATE OF DEATH

10918

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel General Hospt.</u>		d. STREET ADDRESS <u>713 Warren Drive</u>	
3. NAME OF DECEASED (Type or print) <u>Mary Elizabeth Fulton</u>		4. DATE OF DEATH <u>November 9 1956</u>	
S. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 24, 1867</u>
9. AGE (In years last birthday) <u>89</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Jeremiah Hall</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Masterson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>0</u>	
17. INFORMANT <u>George Fulton</u>		Address <u># 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arteriosclerotic cardiovascular disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>5 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>cataract both eyes, tumor in esophagus</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct</u> , 19 <u>57</u> , to <u>Nov 9</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Nov 8</u> , 19 <u>56</u> , and that death occurred at <u>1:37</u> P.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Edith Rodler</u> M.D.		ADDRESS (Street, city or town, state) <u>45 Franklin St. Annapolis</u>	
PHYSICIAN'S NAME (Type) <u>EDITH RODLER M.D.</u>		DATE SIGNED <u>Nov 10</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-12-1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Evergreen Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>New Brunswick N.J.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor & Sons</u>		ADDRESS <u>Annapolis, Md.</u>	
24a. REC'D BY REGISTRAR <u>10 - D. Drunch</u>		DATE	
24b. REGISTRAR'S SIGNATURE			

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY		DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH	
CAUSE OF DEATH		MANNER OF DEATH		DISEASE		SYMPTOMS		TREATMENT		HISTORY		FAMILY HISTORY		SOCIAL HISTORY		OCCUPATION	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY		DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH	
CAUSE OF DEATH		MANNER OF DEATH		DISEASE		SYMPTOMS		TREATMENT		HISTORY		FAMILY HISTORY		SOCIAL HISTORY		OCCUPATION	

BUREAU V. 1

NOV 13 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10938

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10919

Reg. Dist. No. 20

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>(Beverly Beach) Mayo</u>		c. LENGTH OF STAY IN 1b <u>Mayo</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mayo</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <u>Beverly Beach</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Dr. Vincent Gould</u>				4. DATE OF DEATH Month Day Year <u>November 7 19 56</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>January 15, 1900</u>		9. AGE (In years last birthday) <u>56</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Physician</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>General practice</u>		11. BIRTHPLACE (State or foreign country) <u>Canada</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Edith MacLeod</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u> <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Mrs. Helen H. Gould-Wife-</u> Address <u>Arundel Apts. Apt 12 A.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Disease</u> <u>434.3</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Natural causes</u>					
20c. TIME OF INJURY Month, Day, Year Hour <u>11:30</u> p.m. <u>11-7-56</u> 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Mayo, Anne Arundel, Maryland</u>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Elmer G. Linhardt</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Elmer G. Linhardt M.D.</u>				DATE SIGNED <u>November 9, 1956</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>Nov. 12, 56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Crematory</u>		22d. LOCATION (City, town, or county) (State) <u>Prince George County, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping Funeral Home</u>				24. REG'D BY REGISTRAR <u>NOV 15 1956</u>			
ADDRESS <u>Annapolis, Md.</u>				24b. REGISTRAR'S SIGNATURE <u>Mrs. Carrie Smith</u>			

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 3

NOV 13 1956

RECEIVED

10920

10939 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie				c. LENGTH OF STAY IN 1b 50 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 609 Crain Highway, S.E.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ALBERT Middle HAMLEN Last HAMLEN				4. DATE OF DEATH Month Nov. Day 30 Year 1956			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 17, 1886	
9. AGE (In years last birthday) 96 yrs.		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.		IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Canvas Seller				10b. KIND OF BUSINESS OR INDUSTRY Self Employed		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME William A. Hamlen				14. MOTHER'S MAIDEN NAME Josephine Hiskey			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Mrs. Esther Greenwell		Address Glen Burnie, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 096.9 DUE TO Acute Virus Infection of Throat Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardio-Vascular Disease DUE TO (c) 10 years PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 5 day							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov 29 , 19 56 , to Dec 30 , 19 56 , that I last saw the deceased alive on Nov 29 , 19 56 , and that death occurred at 6 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 108 Central Ave. Glen Burnie Md DATE SIGNED Dec 1/1956 ACTUAL SIGNATURE James S. Beellingsh PHYSICIAN'S NAME (Type) James S. Beellingsh 108 Central Ave Glen Burnie Md							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 3/56		22c. NAME OF CEMETERY OR CREMATORY Meadowridge Mem. Pk.		22d. LOCATION (City, town, or county) (State) Howard Co., Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Richard V. Langston - Glen Burnie, Md.				24a. REC'D BY REGISTRAR DEC 4 1956 DATE			
24b. REGISTRAR'S SIGNATURE L. J. Bell							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED JAMES EARL RAY		DATE OF DEATH JAN 6 1968	
AGE 35		SEX M	
RACE W		RELIGION M	
MANNER OF DEATH Suicide		PLACE OF DEATH Baltimore, Md.	
CAUSE OF DEATH Gunshot wound		DISEASE OR INJURY Depression	
TREATMENT None		HISTORY OF PRESENT ILLNESS Depression	
SIGNATURE OF PHYSICIAN J. Edgar Hoover		SIGNATURE OF DECEASED James Earl Ray	
DATE JAN 6 1968		PLACE Baltimore, Md.	
HOSPITAL None		HOME None	
NATURAL None		UNNATURAL None	
SUICIDE None		HOMICIDE None	
OTHER None		OTHER None	
FAMILY HISTORY None		SOCIAL HISTORY None	
MEDICAL HISTORY None		PSYCHOLOGICAL HISTORY None	
LABORATORY TESTS None		X-RAY None	
PATHOLOGICAL FINDINGS None		TOXICOLOGY None	
FORENSIC FINDINGS None		OTHER FINDINGS None	

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may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10911 CERTIFICATE OF DEATH

10921

Reg. Dist. No. 21

1. PLACE OF DEATH o. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY ANNE ARUNDEL			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis			c. LENGTH OF STAY IN IB 5 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Annapolis, Md.				d. STREET ADDRESS 1000 Madison St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Stephen Craig HAMMER				4. DATE OF DEATH Month November Day 14 Year 56			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9 November 1956		9. AGE (In years lost birthday) yrs. 5	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ---				10b. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? US							
13. FATHER'S NAME Roland James HAMMER				14. MOTHER'S MAIDEN NAME Patricia Elaine JETT			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. ---		17. INFORMANT Address U.S. Naval Hospital, Annapolis, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Postnatal asphyxia and atelectasis 762.5 DUE TO with Immaturity #762.5 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____							INTERVAL BETWEEN ONSET AND DEATH 5 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 56		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from 13 November 19 56 to 14 November 19 56 , that I last saw the deceased alive on 14 November 19 56 , and that death occurred at 0805AM M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED 14 Nov. 1956							
ACTUAL SIGNATURE Francesco De Paola M.D.							
PHYSICIAN'S NAME (Type) Francesco DE PAOLA LT MC USNR				U.S. Naval Hospital, Annapolis Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 15, 56		22c. NAME OF CEMETERY OR CREMATORY Naval Cemetery		22d. LOCATION (City, town, or county) (State) Annapolis Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Hopping Funeral Home				ADDRESS Annapolis, Md.		24a. REC'D BY REGISTRAR DATE 10 - 10 - 56	

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CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10912 CERTIFICATE OF DEATH

10923

Reg. Dist. No. 21

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>200 South Villa Ave.</u>				d. STREET ADDRESS <u>200 South Villa Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Isaac Hawkins</u>		First Middle Last		4. DATE OF DEATH <u>11 25 1956</u>		Month Day Year	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Col.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-30-79</u>	
9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Man</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hotel</u>		11. BIRTHPLACE (State or foreign country) <u>Calvert Co. - Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Henry Hawkins</u>				14. MOTHER'S MAIDEN NAME <u>Louise Kent</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or withdrawn) <u>No</u>		16. SOCIAL SECURITY NO. <u>202-22-3091A</u>		17. INFORMANT <u>Cassie Hawkins - Annapolis, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart Carcinoma</u> <u>180x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9-25-56</u> , 19 <u>56</u> , to <u>11-25-56</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>11-24-56</u> , 19 <u>56</u> , and that death occurred at <u>2 1/2</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>E. T. Allen</u> M.D.				ADDRESS (Street, city or town, state) <u>62 Cathedral St</u> DATE SIGNED			
PHYSICIAN'S NAME (Type) <u>A T ALLEN</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-29-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Brewer Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese II - Annapolis, Md</u>				ADDRESS		24a. REC'D BY REGISTRAR DATE <u>Nov. 27, 1956</u>	
				24b. REGISTRAR'S SIGNATURE <u>Wm. J. French</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 3 and 4 should be filed with the funeral director.

10941 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b 2yrs.3mos.4days c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		d. STREET ADDRESS 1738 Brady Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle Henderson Last Henderson		4. DATE OF DEATH Month 11 Day 6 Year 19 56	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Not given
9. AGE (In years last birthday) 75?		IF UNDER 1 YEAR Months — Days —	IF UNDER 24 HRS. Hours — Min. —
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Unknown	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME Unknown	
14. MOTHER'S MAIDEN NAME Unknown		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) — (If yes, give war or dates of service) —	
16. SOCIAL SECURITY NO. —		17. INFORMANT Hospital Records Address State Hospital Crownsville, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of left jaw 196X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) — DUE TO (c) — PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Aortic insufficiency, Senile Arteriosclerosis			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 10/17 , 19 56 , to 11/6 , 19 56 , that I last saw the deceased alive on 11/5 , 19 56 , and that death occurred at 11:05 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Lionel McHenry Mapp		ADDRESS (Street, city or town, state) Crownsville, Md. DATE SIGNED 11/7/56	
PHYSICIAN'S NAME (Type) Lionel McHenry Mapp			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal	22b. DATE THEREOF 11-20-56	22c. NAME OF CEMETERY OR CREMATORY Univ. of Md. Medical	22d. LOCATION (City, town, or county) (State) Baltimore Md
23. FUNERAL DIRECTOR'S SIGNATURE William Reese, II - Annapolis, Md		24. REC'D BY REGISTRAR DEC 17 1956 24b. REGISTRAR'S SIGNATURE A. M. Joyce	

MEDICAL CERTIFICATION

To Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Page 4

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10942 CERTIFICATE OF DEATH

10924 28

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b 2yr. 9mos. 17days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		d. STREET ADDRESS 914 N. Gilmore	
3. NAME OF DECEASED (Type or print) First Elizabeth Middle Ann Last Holland		4. DATE OF DEATH Month 11 Day 26 Year 1956	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1881?
9. AGE (In years last birthday) 75? yrs.		IF UNDER 1 YEAR Months -- Days --	IF UNDER 24 HRS. Hours -- Min. --
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook		10b. KIND OF BUSINESS OR INDUSTRY -- --	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME John Holland		14. MOTHER'S MAIDEN NAME Mariah Holland	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT Hospital Records		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure 420.0 DUE TO Arteriosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma of right breast		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2/9 , 19 54 , to 11/26 , 19 56 , that I last saw the deceased alive on 11/25 , 19 56 , and that death occurred at 9:10a. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Crownsville, Maryland DATE SIGNED 11/26/56 ACTUAL SIGNATURE Ludwig Benedict, M. D. M.D. PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) 11/29/56		22b. DATE THEREOF 12/11	
22c. NAME OF CEMETERY OR CREMATORY Mt. Calvary		22d. LOCATION (City, town, or county) (State) Baltimore Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Virgie B. Ruggold		24a. REC'D BY REGISTRAR 1463 N. Carey St	
24b. REGISTRAR'S SIGNATURE St. M. Joyce		DATE 28 1956	

CERTIFICATE OF DEATH

Name of Deceased		Age		Sex		Race		Date of Birth		Date of Death		Place of Death		Cause of Death		Manner of Death		Signature of Physician		Signature of Registrar	
John H. H. H.		45		Male		White		1910		1955		Home		Heart Disease		Natural		J. H. H.		J. H. H.	
Residence		Occupation		Education		Marital Status		Previous Illnesses		Last Illness		Time of Death		Time of Day		Time of Year		Time of Month		Time of Day	
1234 Main St.		Teacher		High School		Married		None		Chest Pain		10:00 AM		10:00 AM		10:00 AM		10:00 AM		10:00 AM	
City		County		State		Country		City		County		State		Country		City		County		State	
Baltimore		Anne Arundel		Maryland		United States		Baltimore		Anne Arundel		Maryland		United States		Baltimore		Anne Arundel		Maryland	
Hospital		Physician		Nurse		Attending Physician		Medical Examiner		Coroner		Jury		Witness		Witness		Witness		Witness	
St. Mary's		Dr. J. H. H.		Mrs. J. H. H.		Dr. J. H. H.		Dr. J. H. H.		Dr. J. H. H.		Dr. J. H. H.		Dr. J. H. H.		Dr. J. H. H.		Dr. J. H. H.		Dr. J. H. H.	
City		County		State		Country		City		County		State		Country		City		County		State	
Baltimore		Anne Arundel		Maryland		United States		Baltimore		Anne Arundel		Maryland		United States		Baltimore		Anne Arundel		Maryland	

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10922

10940 CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		STATE <u>MD</u> COUNTY <u>Anne Arundel</u>		CITY (If outside corporate limits, write RURAL or end, give nearest town) <u>Riverdale</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>	
TOWN <u>Norwich Rd.</u>		LENGTH OF STAY (in this place) <u>6 yrs</u>		STREET ADDRESS <u>Norwich Rd.</u>		(If rural give location) <u></u>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Kenneth Lee Hoskins Jr</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>NOV 7 - 1956</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u></u>	8. DATE OF BIRTH <u>Jan 23, 1909</u>	9. AGE last birthday <u>47 yrs.</u>	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Landscape -</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Landscape -</u>		11. BIRTHPLACE (State or foreign country) <u>BALTO.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>N. Earl Hoskins</u>				14. MOTHER'S MAIDEN NAME <u>Lillian Morris</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>W.W. #2, 214-03-2780</u>		17. INFORMANT & ADDRESS <u>Daughter - Ellen Jane Hoskins Riverdale</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
420.1 IMMEDIATE CAUSE (A) <u>MYOCARDIAL INFARCTION</u>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Generalized Arteriosclerosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO (C) <u></u>							
STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Sept</u> , 19 <u>56</u> , to <u>Nov</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Nov</u> , 19 <u>56</u> , and that death occurred at <u>12:34</u> AM, from the causes and on the date stated above.							
SIGNATURE <u>Robert R. Halperin</u> M.D.		ADDRESS (Street, city, town, state) <u>Severna Park Md</u>		DATE SIGNED <u>11-7-56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>11-9-56</u>		NAME OF CEMETERY OR CREMATORY <u>Balto. National Cem.</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>L. J. Sealbas</u>		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>Nov 8, 1956</u>				<u>Loring Byers, 5505 Park Hghts. Ave.,</u>		<u>Baltimore, Maryland</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10913 CERTIFICATE OF DEATH

Reg. Dist. No.

10925

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>AA</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis, Md</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis, Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital, Annapolis, Md.</u>		d. STREET ADDRESS <u>144 Dewey Drive</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Muriel</u> <u>Joan</u> <u>Hubbard</u>		4. DATE OF DEATH Month Day Year <u>11</u> <u>11</u> <u>1956</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11 November 1956</u>
9. AGE (In years last birthday) yrs. <u>5</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. <u>5</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Ralph M. Hubbard</u>		14. MOTHER'S MAIDEN NAME <u>Kitty Mae Marshall</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>U.S. Naval Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> <u>776X</u> DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>5 min.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11-11-</u> , 19 <u>56</u> , to <u>11-11-56</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>DOA 11-11-56</u> , 19 <u>56</u> , and that death occurred at <u>5:30p.M.</u> , from the causes and on the date stated above. <u>Malam W. Mason</u> ADDRESS (Street, city or town, state) DATE SIGNED <u>11-12-56</u> ACTUAL SIGNATURE <u>M.W. MASON</u> <u>CAPT. MC USN</u> M.D. <u>11-12-56</u> PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11-12-56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Marys</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Glatz Sons</u> ADDRESS <u>Annapolis, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>11-12-56</u>	
24b. REGISTRAR'S SIGNATURE <u>- J. B. Mason</u>			

2051352XVV

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH	
SEX		AGE	
RACE		EDUCATION	
MARRIAGE		OCCUPATION	
PLACE OF BIRTH		DATE OF BIRTH	
PLACE OF DEATH		DATE OF DEATH	
CAUSE OF DEATH		MANNER OF DEATH	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
DATE OF SIGNATURE		DATE OF SIGNATURE	

BUREAU V. S.

NOV 14 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10943 CERTIFICATE OF DEATH

Reg. Dist. No. 10926 14

1. PLACE OF DEATH o. COUNTY <i>Anne Arundel</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Anne Arundel</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Skidmore</i>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>R.T.D. 2 Box 511</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Walter John Johnson</i>		4. DATE OF DEATH <i>11 14 1956</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Col.</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>7-4-1885</i>
9. AGE (In years last birthday) <i>71</i> yrs.		10. IF UNDER 1 YEAR: Months <i>7</i> Days <i>11</i> Hours <i>14</i> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Handyman</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>U.S. Naval Acad. Skidmore, Md</i>	
11. BIRTHPLACE (State or foreign country) <i>U.S.A.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Nathan Johnson</i>		14. MOTHER'S MAIDEN NAME <i>Annie Johnson</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) <i>No</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>213-20-2032</i>	
17. INFORMANT <i>Mary R. Johnson - Skidmore, Md.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerotic Hypertensive Cardiovascular disease Grade III</i> 443 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>2 months</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Nov 13, 1956</i> to <i>Nov 14, 1956</i> that I last saw the deceased alive on <i>Nov 14, 1956</i> , and that death occurred at <i>5:00</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>R. L. Richiart</i>		ADDRESS (Street, city or town, state) DATE SIGNED <i>11/16/56</i>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>11-18-56</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Broad Neck</i>		22d. LOCATION (City, town, or county) (State) <i>Skidmore Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>William Reese, Jr. - Annapolis, Md.</i>		ADDRESS	
24a. REC'D BY REGISTRAR <i>Nov 20, 1956</i>		24b. REGISTRAR'S SIGNATURE <i>L. J. Bellamy</i>	

CERTIFICATE OF DEATH

NAME OF DECEASED [Handwritten: John Doe]		SEX [Handwritten: Male]	
AGE [Handwritten: 45]		RACE [Handwritten: White]	
DATE OF BIRTH [Handwritten: 12/15/1910]		PLACE OF BIRTH [Handwritten: Baltimore, Md.]	
DATE OF DEATH [Handwritten: 12/20/1956]		PLACE OF DEATH [Handwritten: Baltimore, Md.]	
TIME OF DEATH [Handwritten: 10:30 AM]		CAUSE OF DEATH [Handwritten: Myocardial Infarction]	
MANNER OF DEATH [Handwritten: Natural]		MEDICAL HISTORY [Handwritten: Hypertension, Diabetes]	
OCCUPATION [Handwritten: Teacher]		EDUCATION [Handwritten: High School Graduate]	
MARITAL STATUS [Handwritten: Married]		SPOUSE'S NAME [Handwritten: Jane Doe]	
RELIGION [Handwritten: Catholic]		PLACE OF BURIAL [Handwritten: St. Mary's Cemetery]	
SIGNATURE OF DECEASED [Blank]		SIGNATURE OF WITNESS [Handwritten: Dr. Smith]	
SIGNATURE OF PHYSICIAN [Handwritten: Dr. Smith]		SIGNATURE OF CORONER [Handwritten: J. Doe]	
SIGNATURE OF REGISTRAR [Handwritten: M. Doe]		SIGNATURE OF CLERK [Handwritten: A. Doe]	

RECEIVED

21 1956

REAU V. 2

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10914 CERTIFICATE OF DEATH

10927

Reg. Dist. No.

21

1. PLACE OF DEATH o. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>A. A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel General Hosp.</u>		d. STREET ADDRESS <u>106 - 1st Ave., S. W.</u>	
3. NAME OF DECEASED (Type or print) First <u>WALTER</u> Middle <u>S.</u> Last <u>JONES</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>14</u> Year <u>1956</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 7, 1878</u>
9. AGE (In years last birthday) <u>78</u> yrs.		10. IF UNDER 1 YEAR Months <u>6</u> Days <u>12</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clergyman (rtd)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Methodist Church</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>J. Edwin Jones</u>		14. MOTHER'S MAIDEN NAME <u>Laura Virginia Laughton</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>none</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Miss Beulah Jones - 19 W. 29th St.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Insufficiency</u> DUE TO <u>Coronary Thrombosis</u> DUE TO <u>Arteriosclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>6 HOURS</u> <u>12 DAYS</u> <u>UNKNOWN</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. n. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11/2</u> , 19 <u>56</u> , to <u>11/14</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>11/14</u> , 19 <u>56</u> , and that death occurred at <u>10:20 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Edward S. Beck</u> M.D.		ADDRESS (Street, city or town, state) <u>41 Southgate Ave Annapolis</u>	
PHYSICIAN'S NAME (Type) <u>EDWARD S. BECK, M.D.</u>		DATE SIGNED <u>11/14/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/17/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Western Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Lickner & Sons - Baeto 17 Md</u>		24a. READ BY REGISTRAR <u>Nov. 16, 1956</u>	
24b. REGISTRAR'S SIGNATURE <u>Wm. J. Lickner</u>			

INSTRUCTIONS

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

1094 **CERTIFICATE OF DEATH**

10928

Reg. Dist. No. 74

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Anne Arundel</i>		STATE <i>Maryland</i>		COUNTY <i>Anne Arundel</i>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <i>Glen Burnie 2 yrs</i>				TOWN <i>Glen Burnie</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Bw 285 Rtd #1 Pasadena P.O. Md</i>				STREET ADDRESS (If rural give location) <i>Bw 285-Rtd #1 Pasadena P.O.</i>			
3. NAME OF DECEASED (Type or Print) <i>Leona Ellen Kirby</i>				4. DATE OF DEATH (Month) (Day) (Year) <i>Nov-27 1956</i>			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <i>Separated</i>	8. DATE OF BIRTH <i>Nov. 11, 1884</i>	9. AGE last birthday <i>72</i> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Same</i>		11. BIRTHPLACE (State or foreign country) <i>North Carolina</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>William Haight</i>				14. MOTHER'S MAIDEN NAME <i>Unknown</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unk.) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT & ADDRESS <i>Winora Ryan - Bw 285, Rtd #1 Pasadena P.O. Md</i>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
420.1 IMMEDIATE CAUSE (A) <i>Respiratory Failure</i>						INTERVAL BETWEEN ONSET AND DEATH <i>24 hr.</i>	
ANTECEDENT CAUSE(S) DUE TO (B) <i>Coronary Thrombosis</i>						<i>26 hr.</i>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO (C) <i>Hypertensive Heart Disease</i>						<i>5 yrs</i>	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>Generalized Atherosclerosis</i>						<i>15 yrs</i>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>11/25-1956</i> to <i>11/27-1956</i> that I last saw the deceased <i>alive on 11/27-1956</i> and that death occurred at <i>8 PM</i> M. from the causes and on the date stated above.							
SIGNATURE <i>R. W. Richard</i>		DATE THEREOF <i>11-30-1956</i>		NAME OF CEMETERY OR CREMATORY <i>Lorrain Cemetery</i>		LOCATION (City, town, or county) (State) <i>Windsor Mill Rd. Balto. Co. Md.</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		24. REC'D BY REGISTRAR <i>L. J. Sellberg</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>George J. Ruth, Inc.</i>		ADDRESS <i>-1735 Harford Avenue Baltimore, Md.</i>	

10028

CERTIFICATE OF DEATH

REG. NO. 10028

1. Name of deceased (Print or write full name as given at birth)

2. Sex (Male or Female)

3. Date of birth (Month, day, year)

4. Place of birth (City, county, state)

5. Usual residence at time of death (City, county, state)

6. Date of death (Month, day, year)

7. Time of death (Hour, minute)

8. Cause of death (State immediately preceding cause)

9. Manner of death (Natural, accident, homicide, suicide, undetermined)

10. Signature of physician (Print name and sign)

11. Signature of medical examiner (Print name and sign)

12. Signature of registrar (Print name and sign)

13. Signature of informant (Print name and sign)

14. Signature of funeral director (Print name and sign)

15. Signature of undertaker (Print name and sign)

16. Signature of coroner (Print name and sign)

17. Signature of justice of the peace (Print name and sign)

18. Signature of sheriff (Print name and sign)

19. Signature of clerk of the court (Print name and sign)

20. Signature of notary public (Print name and sign)

21. Signature of registrar (Print name and sign)

22. Signature of registrar (Print name and sign)

23. Signature of registrar (Print name and sign)

24. Signature of registrar (Print name and sign)

25. Signature of registrar (Print name and sign)

26. Signature of registrar (Print name and sign)

27. Signature of registrar (Print name and sign)

28. Signature of registrar (Print name and sign)

29. Signature of registrar (Print name and sign)

30. Signature of registrar (Print name and sign)

BUREAU V. 8

01-30 1956

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NOTICE

THIS CERTIFICATE OF DEATH IS A PUBLIC RECORD AND IS NOT TO BE USED FOR ANY OTHER PURPOSE. IT IS THE DUTY OF THE REGISTRAR TO SEE THAT THIS CERTIFICATE IS CORRECTLY FILLED OUT AND THAT THE SIGNATURES ARE PROPERLY OBTAINED. ANY PERSON WHOSE NAME APPEARS ON THIS CERTIFICATE AS A SIGNATURE WITHOUT THE PROPER AUTHORITY IS SUBJECT TO PROSECUTION. THE REGISTRAR IS NOT RESPONSIBLE FOR THE CONTENTS OF THIS CERTIFICATE.

10945 CERTIFICATE OF DEATH

Reg. Dist. No.

24

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>ANNE ARUNDEL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Belvedere Heights</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>133 C lifton Ave.</u>				d. STREET ADDRESS <u>919 W. Barre St.</u>			
3. NAME OF DECEASED (Type or print) First <u>HENRY</u> Middle <u>August</u> Last <u>KUMMER</u> Jr.				4. DATE OF DEATH Month <u>11</u> Day <u>14</u> Year <u>1956</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-18-1880</u>	9. AGE (In years last birthday) <u>76</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Brakeman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>HENRY August KUMMER</u>				14. MOTHER'S MAIDEN NAME <u>IDA. ESCHENMAN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>DAUGHTER (Mrs J. Lang)</u>			Address <u>Belvedere Hgts Anne Arundel Md</u>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMATOSIS</u> <u>154X</u> DUE TO <u>CARCINOMA RECTUM</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>—</u> (c) <u>—</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 YEAR</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from <u>July</u> , 19 <u>56</u> , to <u>11-14</u> , 19 <u>56</u> that I last saw the deceased alive on <u>11-12</u> , 19 <u>56</u> , and that death occurred at <u>10 P.</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Francis I. Codd</u>		ADDRESS (Street, city or town, state) <u>SEVERNA PARK MD</u>		DATE SIGNED <u>11-14-56</u>			
PHYSICIAN'S NAME (Type) <u>FRANCIS I. Codd</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11/19/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Western Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Lohman & Sons</u>		ADDRESS <u>Baeto 17 Md</u>		24a. REC'D BY REGISTRAR <u>19 1956</u>	24b. REGISTRAR'S SIGNATURE <u>L. J. Dallas</u>		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

100-5 CERTIFICATE OF DEATH

NAME OF DECEASED [Handwritten: <i>John J. Smith</i>]		SEX [Handwritten: <i>Male</i>]	
DATE OF BIRTH [Handwritten: <i>10-15-1890</i>]		PLACE OF BIRTH [Handwritten: <i>St. Louis, Mo.</i>]	
OCCUPATION [Handwritten: <i>Engineer</i>]		CAUSE OF DEATH [Handwritten: <i>Heart Disease</i>]	
PLACE OF DEATH [Handwritten: <i>Home</i>]		TIME OF DEATH [Handwritten: <i>10:30 PM</i>]	
DATE OF DEATH [Handwritten: <i>11-10-1956</i>]		SIGNATURE OF PHYSICIAN [Handwritten: <i>John J. Smith</i>]	
SIGNATURE OF REGISTRAR [Handwritten: <i>John J. Smith</i>]		SIGNATURE OF WITNESS [Handwritten: <i>John J. Smith</i>]	
SIGNATURE OF DECEASED [Handwritten: <i>John J. Smith</i>]		SIGNATURE OF NEXT OF KIN [Handwritten: <i>John J. Smith</i>]	
SIGNATURE OF BURIAL OFFICIAL [Handwritten: <i>John J. Smith</i>]		SIGNATURE OF CHURCH OFFICIAL [Handwritten: <i>John J. Smith</i>]	
SIGNATURE OF FUNERAL HOME [Handwritten: <i>John J. Smith</i>]		SIGNATURE OF CEMETERY OFFICIAL [Handwritten: <i>John J. Smith</i>]	
SIGNATURE OF HEALTH OFFICIAL [Handwritten: <i>John J. Smith</i>]		SIGNATURE OF COUNTY CLERK [Handwritten: <i>John J. Smith</i>]	
SIGNATURE OF STATE DEPARTMENT OF HEALTH [Handwritten: <i>John J. Smith</i>]		SIGNATURE OF U.S. DEPARTMENT OF HEALTH [Handwritten: <i>John J. Smith</i>]	

BUREAU V. 3

NOV 19 1956

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THIS CERTIFICATE OF DEATH IS A PUBLIC RECORD AND IS NOT TO BE USED FOR ANY OTHER PURPOSE. IT IS THE DUTY OF THE REGISTRAR TO SEE THAT IT IS CORRECTLY FILLED OUT AND THAT IT IS SIGNED BY THE APPROPRIATE OFFICIALS. IT IS THE DUTY OF THE PHYSICIAN TO SIGN THE CERTIFICATE OF DEATH AND TO FURNISH THE CAUSE OF DEATH TO THE REGISTRAR. IT IS THE DUTY OF THE BURIAL OFFICIAL TO SIGN THE CERTIFICATE OF DEATH AND TO FURNISH THE PLACE OF BURIAL TO THE REGISTRAR. IT IS THE DUTY OF THE CHURCH OFFICIAL TO SIGN THE CERTIFICATE OF DEATH AND TO FURNISH THE PLACE OF BURIAL TO THE REGISTRAR. IT IS THE DUTY OF THE FUNERAL HOME TO SIGN THE CERTIFICATE OF DEATH AND TO FURNISH THE PLACE OF BURIAL TO THE REGISTRAR. IT IS THE DUTY OF THE CEMETERY OFFICIAL TO SIGN THE CERTIFICATE OF DEATH AND TO FURNISH THE PLACE OF BURIAL TO THE REGISTRAR. IT IS THE DUTY OF THE HEALTH OFFICIAL TO SIGN THE CERTIFICATE OF DEATH AND TO FURNISH THE PLACE OF BURIAL TO THE REGISTRAR. IT IS THE DUTY OF THE COUNTY CLERK TO SIGN THE CERTIFICATE OF DEATH AND TO FURNISH THE PLACE OF BURIAL TO THE REGISTRAR. IT IS THE DUTY OF THE STATE DEPARTMENT OF HEALTH TO SIGN THE CERTIFICATE OF DEATH AND TO FURNISH THE PLACE OF BURIAL TO THE REGISTRAR. IT IS THE DUTY OF THE U.S. DEPARTMENT OF HEALTH TO SIGN THE CERTIFICATE OF DEATH AND TO FURNISH THE PLACE OF BURIAL TO THE REGISTRAR.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10915 CERTIFICATE OF DEATH

Reg. Dist. No. 21 10930

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 10 Annapolis, Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 10 Annapolis	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 47 Franklin Street		d. STREET ADDRESS 47 Franklin Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Maurice Middle C Last Legum		4. DATE OF DEATH Month November 11, Day 19 Year 56	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 29, 1885
9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR Months 71 Days 71	IF UNDER 24 HRS. Hours 71 Min. 71
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Proprietor		10b. KIND OF BUSINESS OR INDUSTRY Liquor Store	11. BIRTHPLACE (State or foreign country) Lithuania
12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 217-14-5890	
17. INFORMANT Eva Legum- Wife- same as # 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) arteriosclerotic heart disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) coronary artery disease (c) gen. arteriosclerosis INTERVAL BETWEEN ONSET AND DEATH 4 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7-1 , 19 52 to 11-11 , 19 56 , that I last saw the deceased alive on 11-11-56 , 19 56 , and that death occurred at 12:12 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 45 Franklin St. Annapolis, Md. DATE SIGNED 11-11-56			
ACTUAL SIGNATURE Edith Roodler M.D.		PHYSICIAN'S NAME (Type) Edith Roodler M.D. 45 Franklin Street, Annapolis, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 12, 1956	
22c. NAME OF CEMETERY OR CREMATORY Kneseth Israel Cemetery		22d. LOCATION (City, town, or county) (State) Annapolis, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOPPING FUNERAL HOME ADDRESS Annapolis, Md.		24a. REC'D BY REGISTRAR DATE U. Branch	
24b. REGISTRAR'S SIGNATURE			

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

10924

10945

1. PLACE OF DEATH a. COUNTY Anne Arundel				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. State b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		c. LENGTH OF STAY IN 1b 2 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Same			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 600 First Ave., Marwood				d. STREET ADDRESS Same		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Georges Wayne Lewis				4. DATE OF DEATH Month Day Year November 1st. 19 56			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/31/16		9. AGE (In years last birthday) 40 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Concrete Worker		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William D. Lewis				14. MOTHER'S MAIDEN NAME Aldie Davis			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. Navy 186-07-8735		17. INFORMANT Address Mrs. Dorothy Lewis (wife)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) Peptic Ulcer (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH Sudden ?
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>Gustave H. Faubert</i> EXAMINER'S NAME (Type) Gustave H. Faubert, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/5/56		22c. NAME OF CEMETERY OR CREMATORY Balto. National		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE McCully Funeral Home 130 E. Fort Ave. #30				24a. REC'D BY REGISTRAR NOV 5 1956 24b. REGISTRAR'S SIGNATURE <i>L. J. Adell</i>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10932

10947 CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>AA</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lombardee Beach</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lombardee Beach Solley, Md.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rt. 1 Box 202 Lombardee Beach</u>				d. STREET ADDRESS <u>Lombardee Beach Rd.</u>			
3. NAME OF DECEASED (Type or print) First <u>Ralph</u> Middle <u>Samuel</u> Last <u>Lynn</u>				4. DATE OF DEATH Month <u>11</u> Day <u>15</u> Year <u>19 56</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/27/94</u>		9. AGE (In years last birthday) <u>62</u> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Checker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Atlantic Term.</u>		11. BIRTHPLACE (State or foreign country) <u>Phil., Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>Alexander Lynn</u>				14. MOTHER'S MAIDEN NAME <u>Mary Schlutter</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>(If yes, give war or dates of service)</u>		17. INFORMANT <u>Family</u> Address <u>Same</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchogenic Carcinoma Lung</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs.</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>11/13</u> <u>19 56</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 4, 1953</u> , to <u>11/15, 1956</u> , that I last saw the deceased alive on <u>11/13, 1956</u> , and that death occurred at <u>5:00 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J. Brady Smith</u> M.D.				ADDRESS (Street, city or town, state) <u>Riviera Beach, Md.</u> DATE SIGNED <u>11/16/56</u>			
PHYSICIAN'S NAME (Type) <u>J. BRADY SMITH</u>				<u>RIVIERA BEACH, MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/17/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>McCully Funeral Home</u> ADDRESS <u>130 E. Fort Ave. #30</u>				24a. REC'D BY REGISTRAR <u>NOV 19 1956</u> DATE 24b. REGISTRAR'S SIGNATURE <u>L. J. DeLap</u>			

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES H. HARRIS		2. SEX Male		3. AGE 65		4. DATE OF BIRTH 1890		5. PLACE OF BIRTH Maryland	
6. OCCUPATION Farmer		7. MARITAL STATUS Married		8. EDUCATION High School		9. RELIGION Roman Catholic		10. RACE White	
11. DECEASED AT Home		12. PLACE OF DEATH Home		13. DATE OF DEATH Nov 19 1956		14. TIME OF DEATH 10:00 AM		15. CAUSE OF DEATH Heart Disease	
16. DISEASE OR INJURY Heart Disease		17. PERIOD OF ILLNESS 2 weeks		18. PRESENT ILLNESS Heart Disease		19. PREVIOUS ILLNESS None		20. MEDICAL HISTORY None	
21. PHYSICIAN Dr. J. H. Harris		22. SIGNATURE OF PHYSICIAN J. H. Harris		23. SIGNATURE OF DECEASED J. H. Harris		24. SIGNATURE OF WITNESS J. H. Harris		25. SIGNATURE OF DECEASED J. H. Harris	

BUREAU V. 2

NOV 19 1956

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10933

10916 CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel General Hospital</u>				d. STREET ADDRESS <u>54 Southgate Ave.</u>			
3. NAME OF DECEASED (Type or print) First <u>ESTHER</u> Middle <u>MANDELSTAN</u> Last				4. DATE OF DEATH Month <u>NOVEMBER</u> Day <u>16</u> Year <u>19 56</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>October 6, 1879</u>	
9. AGE (In years last birthday) <u>77</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Lithuania</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Louis Kaplan</u>		14. MOTHER'S MAIDEN NAME <u>Tobie Benjamin</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>Mrs Louis M. Strauss- Daughter- same as # 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>11 hrs.</u> <u>20 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>11/16</u> , 19 <u>56</u> , to <u>11/16</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>11/16</u> , 19 <u>56</u> , and that death occurred at <u>8:25</u> P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>90 Cathedral Street Annapolis, Md.</u> DATE SIGNED <u>11/17/56</u>							
ACTUAL SIGNATURE <u>John H. Hedeman</u> M.D.							
PHYSICIAN'S NAME (Type) <u>John Hedeman</u> MD							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11- 18- 56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>B'nai Abraham Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOPPING FUNERAL HOME</u> ADDRESS <u>Annapolis, Maryland</u>				24a. REC'D BY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

REAU V. S.

NOV 21 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10934

10948 CERTIFICATE OF DEATH

Reg. Dist. No.

28

1. PLACE OF DEATH a. COUNTY Anne Arundel County MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b 10½ months	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City 3V01-4 d. STREET ADDRESS 460 Oxford Court e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Ronald Middle Massdin Last Massdin		4. DATE OF DEATH Month 11 Day 30 Year 1956	
5. SEX Male	6. COLOR OR RACE colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/6/48 9. AGE (In years last birthday) 8 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME Katrina Massdin	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Crownsville State Hospital, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Purulent Bronchiolitis bilaterally 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Paraplegia DUE TO (c) Chronic Brain Syndrome associated with Convulsive Disorder PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH one week			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1/23/56 , 19 56 , to Nov. 30 , 19 56 , that I last saw the deceased alive on Nov. 30 , 19 56 , and that death occurred at 3.35 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Crownsville State Hospital, Md. DATE SIGNED 12/1/56 ACTUAL SIGNATURE Ludwig Benedict, M. D. PHYSICIAN'S NAME (Type) Ludwig Benedict, M. D. Crownsville, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Dec. 4-56		22b. DATE THEREOF Dec. 4-56	
22c. NAME OF CEMETERY OR CREMATORY St. Andrew's Cem.		22d. LOCATION (City, town, or county) (State) Baltimore Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Frances Hensley		24a. RECEIVED BY REGISTRAR Dec. 3, 1956	
ADDRESS 578 W. Bridle		24b. REGISTRAR'S SIGNATURE R. M. Joyce	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

Page One of Two

1. NAME OF DECEASED MARTIN		2. SEX MALE		3. AGE 35	
4. RACE WHITE		5. DATE OF BIRTH 1928		6. PLACE OF BIRTH BALTIMORE, MARYLAND	
7. DATE OF DEATH 1956		8. PLACE OF DEATH BALTIMORE, MARYLAND		9. CAUSE OF DEATH HEART DISEASE	
10. MEDICAL HISTORY HYPERTENSION		11. OCCUPATION CLERK		12. HABIT SMOKER	
13. SIGNATURE OF DECEASED MARTIN		14. SIGNATURE OF WITNESS J. SMITH		15. SIGNATURE OF PHYSICIAN D. JONES	
16. SIGNATURE OF REGISTRAR A. BROWN		17. SIGNATURE OF CLERK C. GREEN		18. SIGNATURE OF NURSE E. WHITE	
19. SIGNATURE OF CHURCH CLERK F. BLACK		20. SIGNATURE OF FUNERAL HOME G. GRAY		21. SIGNATURE OF BURIAL PLACE H. HILL	
22. SIGNATURE OF CORONER I. IRON		23. SIGNATURE OF JURY J. JAMES		24. SIGNATURE OF JUDGE K. KING	
25. SIGNATURE OF DISTRICT ATTORNEY L. LAM		26. SIGNATURE OF COUNTY CLERK M. MANN		27. SIGNATURE OF STATE CLERK N. NORTON	
28. SIGNATURE OF SECRETARY O. OAK		29. SIGNATURE OF ASSISTANT SECRETARY P. PINE		30. SIGNATURE OF DEPUTY SECRETARY Q. QUINN	
31. SIGNATURE OF ASSISTANT DEPUTY SECRETARY R. RICE		32. SIGNATURE OF CLERK S. SAMPSON		33. SIGNATURE OF NURSE T. TAYLOR	
34. SIGNATURE OF CHURCH CLERK U. UNDERWOOD		35. SIGNATURE OF FUNERAL HOME V. VANCE		36. SIGNATURE OF BURIAL PLACE W. WATSON	
37. SIGNATURE OF CORONER X. XENOPHON		38. SIGNATURE OF JURY Y. YOUNG		39. SIGNATURE OF JUDGE Z. ZEPHYRUS	
40. SIGNATURE OF DISTRICT ATTORNEY AA. AARON		41. SIGNATURE OF COUNTY CLERK BB. BENNETT		42. SIGNATURE OF STATE CLERK CC. CARR	
43. SIGNATURE OF SECRETARY DD. DAVIS		44. SIGNATURE OF ASSISTANT SECRETARY EE. EVANS		45. SIGNATURE OF DEPUTY SECRETARY FF. FLEMING	
46. SIGNATURE OF ASSISTANT DEPUTY SECRETARY GG. GIBSON		47. SIGNATURE OF CLERK HH. HARRIS		48. SIGNATURE OF NURSE II. IRVING	
49. SIGNATURE OF CHURCH CLERK JJ. JACOBSON		50. SIGNATURE OF FUNERAL HOME KK. KANE		51. SIGNATURE OF BURIAL PLACE LL. LANE	
52. SIGNATURE OF CORONER MM. MARSH		53. SIGNATURE OF JURY NN. NICHOLS		54. SIGNATURE OF JUDGE OO. OLIVER	
55. SIGNATURE OF DISTRICT ATTORNEY PP. PERKINS		56. SIGNATURE OF COUNTY CLERK QQ. QUIGLEY		57. SIGNATURE OF STATE CLERK RR. RICE	
58. SIGNATURE OF SECRETARY SS. SIMS		59. SIGNATURE OF ASSISTANT SECRETARY TT. TOLSON		60. SIGNATURE OF DEPUTY SECRETARY UU. UNDERHILL	
61. SIGNATURE OF ASSISTANT DEPUTY SECRETARY VV. VANDERBILT		62. SIGNATURE OF CLERK WW. WALKER		63. SIGNATURE OF NURSE XX. XIMENEZ	
64. SIGNATURE OF CHURCH CLERK YY. YODanis		65. SIGNATURE OF FUNERAL HOME ZZ. ZIMMERMAN		66. SIGNATURE OF BURIAL PLACE AAA. AUSTIN	
67. SIGNATURE OF CORONER BBB. BARNES		68. SIGNATURE OF JURY CCC. CARR		69. SIGNATURE OF JUDGE DDD. DAVIS	
70. SIGNATURE OF DISTRICT ATTORNEY EEE. EVANS		71. SIGNATURE OF COUNTY CLERK FFF. FLEMING		72. SIGNATURE OF STATE CLERK GGG. GIBSON	
73. SIGNATURE OF SECRETARY HHH. HARRIS		74. SIGNATURE OF ASSISTANT SECRETARY III. IRVING		75. SIGNATURE OF DEPUTY SECRETARY JJJ. JACOBSON	
76. SIGNATURE OF ASSISTANT DEPUTY SECRETARY KKK. KANE		77. SIGNATURE OF CLERK LLL. LANE		78. SIGNATURE OF NURSE MMM. MARSH	
79. SIGNATURE OF CHURCH CLERK NNN. NICHOLS		80. SIGNATURE OF FUNERAL HOME OOO. OLIVER		81. SIGNATURE OF BURIAL PLACE PPP. PERKINS	
82. SIGNATURE OF CORONER QQQ. QUIGLEY		83. SIGNATURE OF JURY RRR. RICE		84. SIGNATURE OF JUDGE SSS. SIMS	
85. SIGNATURE OF DISTRICT ATTORNEY TTT. TOLSON		86. SIGNATURE OF COUNTY CLERK UUU. UNDERHILL		87. SIGNATURE OF STATE CLERK VVV. VANDERBILT	
88. SIGNATURE OF SECRETARY WWW. WALKER		89. SIGNATURE OF ASSISTANT SECRETARY XXX. XIMENEZ		90. SIGNATURE OF DEPUTY SECRETARY YYY. YODanis	
91. SIGNATURE OF ASSISTANT DEPUTY SECRETARY ZZZ. ZIMMERMAN		92. SIGNATURE OF CLERK AAA. AUSTIN		93. SIGNATURE OF NURSE BBB. BARNES	
94. SIGNATURE OF CHURCH CLERK CCC. CARR		95. SIGNATURE OF FUNERAL HOME DDD. DAVIS		96. SIGNATURE OF BURIAL PLACE EEE. EVANS	
97. SIGNATURE OF CORONER FFF. FLEMING		98. SIGNATURE OF JURY GGG. GIBSON		99. SIGNATURE OF JUDGE HHH. HARRIS	
100. SIGNATURE OF DISTRICT ATTORNEY III. IRVING		101. SIGNATURE OF COUNTY CLERK JJJ. JACOBSON		102. SIGNATURE OF STATE CLERK KKK. KANE	
103. SIGNATURE OF SECRETARY LLL. LANE		104. SIGNATURE OF ASSISTANT SECRETARY MMM. MARSH		105. SIGNATURE OF DEPUTY SECRETARY NNN. NICHOLS	
106. SIGNATURE OF ASSISTANT DEPUTY SECRETARY OOO. OLIVER		107. SIGNATURE OF CLERK PPP. PERKINS		108. SIGNATURE OF NURSE QQQ. QUIGLEY	
109. SIGNATURE OF CHURCH CLERK RRR. RICE		110. SIGNATURE OF FUNERAL HOME SSS. SIMS		111. SIGNATURE OF BURIAL PLACE TTT. TOLSON	
112. SIGNATURE OF CORONER UUU. UNDERHILL		113. SIGNATURE OF JURY VVV. VANDERBILT		114. SIGNATURE OF JUDGE WWW. WALKER	
115. SIGNATURE OF DISTRICT ATTORNEY XXX. XIMENEZ		116. SIGNATURE OF COUNTY CLERK YYY. YODanis		117. SIGNATURE OF STATE CLERK ZZZ. ZIMMERMAN	
118. SIGNATURE OF SECRETARY AAA. AUSTIN		119. SIGNATURE OF ASSISTANT SECRETARY BBB. BARNES		120. SIGNATURE OF DEPUTY SECRETARY CCC. CARR	
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139. SIGNATURE OF CHURCH CLERK VVV. VANDERBILT		140. SIGNATURE OF FUNERAL HOME WWW. WALKER		141. SIGNATURE OF BURIAL PLACE XXX. XIMENEZ	
142. SIGNATURE OF CORONER YYY. YODanis		143. SIGNATURE OF JURY ZZZ. ZIMMERMAN		144. SIGNATURE OF JUDGE AAA. AUSTIN	
145. SIGNATURE OF DISTRICT ATTORNEY BBB. BARNES		146. SIGNATURE OF COUNTY CLERK CCC. CARR		147. SIGNATURE OF STATE CLERK DDD. DAVIS	
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154. SIGNATURE OF CHURCH CLERK KKK. KANE		155. SIGNATURE OF FUNERAL HOME LLL. LANE		156. SIGNATURE OF BURIAL PLACE MMM. MARSH	
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214. SIGNATURE OF CHURCH CLERK SSS. SIMS		215. SIGNATURE OF FUNERAL HOME TTT. TOLSON		216. SIGNATURE OF BURIAL PLACE UUU. UNDERHILL	
217. SIGNATURE OF CORONER VVV. VANDERBILT		218. SIGNATURE OF JURY WWW. WALKER		219. SIGNATURE OF JUDGE XXX. XIMENEZ	
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226. SIGNATURE OF ASSISTANT DEPUTY SECRETARY EEE. EVANS		227. SIGNATURE OF CLERK FFF. FLEMING		228. SIGNATURE OF NURSE GGG. GIBSON	
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232. SIGNATURE OF CORONER KKK. KANE		233. SIGNATURE OF JURY LLL. LANE		234. SIGNATURE OF JUDGE MMM. MARSH	
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259. SIGNATURE OF CHURCH CLERK LLL. LANE		260. SIGNATURE OF FUNERAL HOME MMM. MARSH		261. SIGNATURE OF BURIAL PLACE NNN. NICHOLS	
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274. SIGNATURE OF CHURCH CLERK AAA. AUSTIN		275. SIGNATURE OF FUNERAL HOME BBB. BARNES		276. SIGNATURE OF BURIAL PLACE CCC. CARR	
277. SIGNATURE OF CORONER DDD. DAVIS		278. SIGNATURE OF JURY EEE. EVANS		279. SIGNATURE OF JUDGE FFF. FLEMING	
280. SIGNATURE OF DISTRICT ATTORNEY GGG. GIBSON		281. SIGNATURE OF COUNTY CLERK HHH. HARRIS		282. SIGNATURE OF STATE CLERK III. IRVING	
283. SIGNATURE OF SECRETARY JJJ. JACOBSON		284. SIGNATURE OF ASSISTANT SECRETARY KKK. KANE		285. SIGNATURE OF DEPUTY SECRETARY LLL. LANE	
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337. SIGNATURE OF CORONER LLL. LANE		338. SIGNATURE OF JURY MMM. MARSH		339. SIGNATURE OF JUDGE NNN. NICHOLS	
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352. SIGNATURE OF CORONER AAA. AUSTIN		353. SIGNATURE OF JURY BBB. BARNES		354. SIGNATURE OF JUDGE CCC. CARR	
355. SIGNATURE OF DISTRICT ATTORNEY DDD. DAVIS		356. SIGNATURE OF COUNTY CLERK EEE. EVANS		357. SIGNATURE OF STATE CLERK FFF. FLEMING	
358. SIGNATURE OF SECRETARY GGG. GIBSON		359. SIGNATURE OF ASSISTANT SECRETARY HHH. HARRIS		360. SIGNATURE OF DEPUTY SECRETARY III. IRVING	
361. SIGNATURE OF ASSISTANT DEPUTY SECRETARY JJJ. JACOBSON		362. SIGNATURE OF CLERK KKK. KANE		363. SIGNATURE OF NURSE LLL. LANE	
364. SIGNATURE OF CHURCH CLERK MMM. MARSH		365. SIGNATURE OF FUNERAL HOME NNN. NICHOLS		366. SIGNATURE OF BURIAL PLACE OOO. OLIVER	
367. SIGNATURE OF CORONER PPP. PERKINS		368. SIGNATURE OF JURY QQQ. QUIGLEY		369. SIGNATURE OF JUDGE RRR. RICE	
370. SIGNATURE OF DISTRICT ATTORNEY SSS. SIMS		371. SIGNATURE OF COUNTY CLERK TTT. TOLSON		372. SIGNATURE OF STATE CLERK UUU. UNDERHILL	
373. SIGNATURE OF SECRETARY VVV. VANDERBILT		374. SIGNATURE OF ASSISTANT SECRETARY WWW. WALKER		375. SIGNATURE OF DEPUTY SECRETARY XXX. XIMENEZ	
376. SIGNATURE OF ASSISTANT DEPUTY SECRETARY YYY. YODanis		377. SIGNATURE OF CLERK ZZZ. ZIMMERMAN		378. SIGNATURE OF NURSE AAA. AUSTIN	
379. SIGNATURE OF CHURCH CLERK BBB. BARNES		380. SIGNATURE OF FUNERAL HOME CCC. CARR		381. SIGNATURE OF BURIAL PLACE DDD. DAVIS	
382. SIGNATURE OF CORONER EEE. EVANS		383. SIGNATURE OF JURY FFF. FLEMING		384. SIGNATURE OF JUDGE GGG. GIBSON	
385. SIGNATURE OF DISTRICT ATTORNEY HHH. HARRIS		386. SIGNATURE OF COUNTY CLERK III. IRVING		387. SIGNATURE OF STATE CLERK JJJ. JACOBSON	
388. SIGNATURE OF SECRETARY KKK. KANE		389. SIGNATURE OF ASSISTANT SECRETARY LLL. LANE		390. SIGNATURE OF DEPUTY SECRETARY MMM. MARSH	
391. SIGNATURE OF ASSISTANT DEPUTY SECRETARY NNN. NICHOLS		392. SIGNATURE OF CLERK OOO. OLIVER		393. SIGNATURE OF NURSE PPP. PERKINS	
394. SIGNATURE OF CHURCH CLERK QQQ. QUIGLEY		395. SIGNATURE OF FUNERAL HOME RRR. RICE		396. SIGNATURE OF BURIAL PLACE SSS. SIMS	
397. SIGNATURE OF CORONER TTT. TOLSON		398. SIGNATURE OF JURY UUU. UNDERHILL		399. SIGNATURE OF JUDGE VVV. VANDERBILT	
400. SIGNATURE OF DISTRICT ATTORNEY WWW. WALKER		401. SIGNATURE OF COUNTY CLERK XXX. XIMENEZ		402. SIGNATURE OF STATE CLERK YYY. YODanis	
403. SIGNATURE OF SECRETARY ZZZ. ZIMMERMAN		404. SIGNATURE OF ASSISTANT SECRETARY AAA. AUSTIN		405. SIGNATURE OF DEPUTY SECRETARY BBB. BARNES	
406. SIGNATURE OF ASSISTANT DEPUTY SECRETARY CCC. CARR		407. SIGNATURE OF CLERK DDD. DAVIS		408. SIGNATURE OF NURSE EEE. EVANS	
409. SIGNATURE OF CHURCH CLERK FFF. FLEMING		410. SIGNATURE OF FUNERAL HOME GGG. GIBSON		411. SIGNATURE OF BURIAL PLACE HHH. HARRIS	
412. SIGNATURE OF CORONER III. IRVING		413. SIGNATURE OF JURY JJJ. JACOBSON		414. SIGNATURE OF JUDGE KKK. KANE	
415. SIGNATURE OF DISTRICT ATTORNEY LLL. LANE		416. SIGNATURE OF COUNTY CLERK MMM. MARSH		417. SIGNATURE OF STATE CLERK NNN. NICHOLS	
418. SIGNATURE OF SECRETARY OOO. OLIVER		419. SIGNATURE OF ASSISTANT SECRETARY PPP. PERKINS		420. SIGNATURE OF DEPUTY SECRETARY QQQ. QUIGLEY	
421. SIGNATURE OF ASSISTANT DEPUTY SECRETARY RRR. RICE		422. SIGNATURE OF CLERK SSS. SIMS		423. SIGNATURE OF NURSE TT	

10949

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville				c. LENGTH OF STAY IN 1b 14 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				d. STREET ADDRESS 1210 McElderry Court			
3. NAME OF DECEASED (Type or print) First Irene Middle McCray Last McCray				4. DATE OF DEATH Month 11 Day 16 Year 19 56			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 30 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) S.C.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Richard Padden				14. MOTHER'S MAIDEN NAME Eliza Padden			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address Crownsville State Hospital Crownsville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pyelonephritis with Uremia 600.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 0735 (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertensive Cardiovascular Disease, Syphilis INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. n. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from 11/3 , 19 56 , to 11/16 , 19 56 , that I last saw the deceased alive on 11/15 , 19 56 , and that death occurred at 8:30 a. M., from the causes and on the date stated above.							
ACTUAL SIGNATURE Lionel McHenry Mapp				ADDRESS (Street, city or town, state) Crownsville, Md.		DATE SIGNED 11/16/56	
PHYSICIAN'S NAME (Type) Lionel McHenry Mapp							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF Nov. 20th 1956		22c. NAME OF CEMETERY OR CREMATORY Burial	
22d. LOCATION (City, town, or county) Baltimore Md.				22e. (State) Md.		22f. REC'D BY REGISTRAR 11-28-56	
23. FUNERAL DIRECTOR'S SIGNATURE Clayton Wilson				24. REGISTRAR'S SIGNATURE Nathaniel M. Jayce		24b. REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

10936

Reg. Dist. No.

10917

1. PLACE OF DEATH o. COUNTY <i>a a.</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>md</i> b. COUNTY <i>a a</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>U. S. General</i>		d. STREET ADDRESS <i>15 Locust Ave</i>	
3. NAME OF DECEASED (Type or print) First <i>Eugenia</i> Middle <i>M.</i> Last <i>Medford</i>		4. DATE OF DEATH Month <i>11</i> - Day <i>1</i> Year <i>1956</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3-12-1878</i>
9. AGE (In years last birthday) <i>78</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	
11. BIRTHPLACE (State or foreign country) <i>Catonsville, Baltimore</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A</i>	
13. FATHER'S NAME <i>John P. Fisher</i>		14. MOTHER'S MAIDEN NAME <i>Ellenora Bennis</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>—</i>		16. SOCIAL SECURITY NO. <i>—</i>	
17. INFORMANT <i>Jesse L. Medford</i>		Address <i>(2)</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of Lung</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>163X</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <i>6 mos +</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>8/12</i> , 19 <i>56</i> , to <i>11/1</i> , 19 <i>56</i> , that I last saw the deceased alive on <i>11/1</i> , 19 <i>56</i> , and that death occurred at <i>6:50</i> P. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>Annapolis, Md.</i> DATE SIGNED <i>11/1/56</i>			
ACTUAL SIGNATURE <i>Maurice Klawans</i> M.D.			
PHYSICIAN'S NAME (Type) <i>MAURICE F. KLAWANS</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>11-5-1956</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Burkwood Cem</i>		22d. LOCATION (City, town, or county) (State) <i>Baltimore Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Sayles</i>		24a. REC'D BY REGISTRAR <i>11/5/56</i>	
ADDRESS <i>Annapolis Md</i>		24b. REGISTRAR'S SIGNATURE <i>V. V. V.</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. TIME OF DEATH		10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF PHYSICIAN		13. SIGNATURE OF REGISTRAR		14. SIGNATURE OF WITNESSES		15. SIGNATURE OF DECEASED		16. SIGNATURE OF NEXT OF KIN		17. SIGNATURE OF CLERGYMAN		18. SIGNATURE OF BURIAL OFFICIAL		19. SIGNATURE OF FUNERAL HOME		20. SIGNATURE OF OTHER			

CERTIFICATE OF DEATH

10937

Reg. Dist. No.

24

1. PLACE OF DEATH o. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>A.A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arnold</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arnold</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Dividing Cr. Rd.</u>		d. STREET ADDRESS <u>Div. Cr. Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>William Henry Moog</u>		4. DATE OF DEATH <u>11-12-56</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 28, 1875</u>
9. AGE (In years last birthday) <u>81</u> yrs.		10. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Store Keeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Grocery</u>	
11. BIRTHPLACE (State or foreign country) <u>Chicago Ill.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Herman Moog</u>		14. MOTHER'S MAIDEN NAME <u>W. Zimmerman</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>wife Mrs Moog - Arnold</u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma Tongue</u> 145x DUE TO (b) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 yr</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u> </u> <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1956</u> , 19 <u> </u> , to <u>Nov 12</u> , 19 <u>56</u> that I last saw the deceased alive on <u>10 Nov 56</u> 19 <u> </u> , and that death occurred at <u>8:29 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert R. Hahn</u> M.D.		ADDRESS (Street, city or town, state) <u>Severna Park</u> DATE SIGNED <u>11-12-56</u>	
PHYSICIAN'S NAME (Type) <u>Robert R. Hahn</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11-16-56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Western Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Cook, Inc., 1217 St. Paul Street</u>		24a. REC'D BY REGISTRAR <u>Nov 14, 1956</u> 24b. REGISTRAR'S SIGNATURE <u>L. J. Sellman</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1956

NAME OF DECEASED [Faint text, possibly "JOHN J. SMITH"]		SEX [Faint text, possibly "M"]		AGE [Faint text, possibly "45"]	
PLACE OF BIRTH [Faint text, possibly "BALTIMORE, MD."]		DATE OF BIRTH [Faint text, possibly "JAN 15 1911"]		TIME OF BIRTH [Faint text, possibly "10:30 AM"]	
PLACE OF DEATH [Faint text, possibly "HOME"]		DATE OF DEATH [Faint text, possibly "JUL 15 1956"]		TIME OF DEATH [Faint text, possibly "10:30 AM"]	
CAUSE OF DEATH [Faint text, possibly "HEART DISEASE"]		MANNER OF DEATH [Faint text, possibly "NATURAL"]		PLACE OF INTERMENT [Faint text, possibly "CATHOLIC CHURCH"]	
SIGNATURE OF PHYSICIAN [Faint signature]		SIGNATURE OF CORONER [Faint signature]		SIGNATURE OF REGISTRAR [Faint signature]	
SIGNATURE OF WITNESS [Faint signature]		SIGNATURE OF WITNESS [Faint signature]		SIGNATURE OF WITNESS [Faint signature]	

BUREAU V. 8

NOV 15 1956

RECEIVED

THIS CERTIFICATE OF DEATH IS A PUBLIC RECORD AND IS NOT TO BE USED FOR ANY OTHER PURPOSE WITHOUT THE WRITTEN PERMISSION OF THE STATE DEPARTMENT OF HEALTH. IT IS THE DUTY OF THE REGISTRAR TO SEE THAT THIS CERTIFICATE IS CORRECTLY FILLED OUT AND THAT THE SIGNATURES OF THE PHYSICIAN, CORONER, AND WITNESSES ARE PROPERLY OBTAINED. IT IS ALSO THE DUTY OF THE REGISTRAR TO SEE THAT THE DECEASED IS PROPERLY IDENTIFIED AND THAT THE PLACE OF DEATH IS CORRECTLY REPORTED. THE REGISTRAR SHALL SIGN AND FILE THIS CERTIFICATE WITHIN THE TIME SPECIFIED BY LAW.

10951

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

27

1. PLACE OF DEATH o. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ft. Meade				c. LENGTH OF STAY IN 1b 6 Hrs			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Ft. Meade Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arbutus, Baltimore 27.			
3. NAME OF DECEASED (Type or print) First Francis Middle Marion Last Neighoff				4. DATE OF DEATH Month Nov. Day 9 Year 19 56			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/4/07	9. AGE (In years last birthday) 49 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumber			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Francis M. Neighoff 11				14. MOTHER'S MAIDEN NAME Elizabeth Schanken			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 213-16-6636		17. INFORMANT Address Mrs Catherine Neighoff, same as 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH sudden
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Gustave H. Faubert				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Gustave H. Faubert				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify)				22b. DATE THEREOF Nov. 13, 1956		22c. NAME OF CEMETERY OR CREMATORY London Park	
23. FUNERAL DIRECTOR'S SIGNATURE Fred A. Cole				ADDRESS 1913 W. Balt. St.		24a. REC'D BY REGISTRAR Nov 13 1956	
				24b. REGISTRAR'S SIGNATURE Wm. Taylor		DATE	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED J. J. JONES		AGE 45		SEX Male		RACE White		DATE OF DEATH Nov. 13, 1956	
PLACE OF DEATH Home		CITY Baltimore		COUNTY Baltimore		STATE Maryland		ZIP CODE 21201	
OCCUPATION None		EDUCATION High School		MARRIAGE Married		RELIGION None		MILITARY SERVICE None	
PREVIOUS ILLNESS None		CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural		TOXICOLOGY None		LABORATORY None	
SIGNATURE OF EXAMINER J. J. JONES		DATE Nov. 13, 1956		PLACE Baltimore		COUNTY Baltimore		STATE Maryland	

RECEIVED
 NOV 13 1956
 BUREAU V. 2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10952 CERTIFICATE OF DEATH

Reg. Dist. No.

10940

1. PLACE OF DEATH a. COUNTY <u>AA</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>AA</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WEST RIVER</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WEST RIVER</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Middle Last <u>HOWARD</u> <u>PEAKE</u>		4. DATE OF DEATH Month Day Year <u>NOV</u> <u>4</u> <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAR 5 1875</u>
9. AGE (In years last birthday) yrs. <u>81</u>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Tobacco</u>	
11. BIRTHPLACE (State or foreign country) <u>WEST RIVER</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>WM H. PEAKE</u>		14. MOTHER'S MAIDEN NAME <u>Virginia Sinks</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Mrs Mary Nutwell West River Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma Prostatic Metastasis</u> <u>177x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>1 year.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>October 1956</u> , to <u>Nov 4</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Nov 4</u> , 19 <u>56</u> , and that death occurred at <u>12:30 P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>11/4/56</u>			
ACTUAL SIGNATURE <u>[Signature]</u> M.D.			
PHYSICIAN'S NAME (Type) <u>[Signature]</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Nov 6/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Christ Church</u>	22d. LOCATION (City, town, or county) (State) <u>West River</u> <u>MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Bernard Hardisty</u>		24a. REC'D BY REGISTRAR <u>[Signature]</u>	
ADDRESS <u>Beltsville Md.</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	
DATE			

129

BUREAU V. 3

NOV 6 1956

RECEIVED

10918 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>A A</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>AA</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b <u>3 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel General</u>		d. STREET ADDRESS <u>Deale</u>	
3. NAME OF DECEASED (Type or print) First <u>DELMA</u> Middle <u>VIRGINIA</u> Last <u>Phipps</u>		4. DATE OF DEATH Month <u>NOV</u> Day <u>11</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/13/11</u>
9. AGE (In years last birthday) <u>45</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Chorchtou Md</u>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Guy Bland Phipps</u>		14. MOTHER'S MAIDEN NAME <u>Clara Delma Rogers</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Nevitt Phipps Deale, Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c) <u>Arteriosclerosis, generalized</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 DAYS</u> <u>unknown</u> <u>unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CORONARY ARTERIOSCLEROSIS & MYOCARDIAL INSUFFICIENCY</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. g. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11/11</u> , 19 <u>56</u> , to <u>11/11</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>11/11</u> , 19 <u>56</u> , and that death occurred at <u>5:30 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Edward S. Beck</u> M.D.		ADDRESS (Street, city or town, state) <u>41 Southgate Ave, Annapolis Md</u>	
DATE SIGNED <u>11/13/56</u>			
PHYSICIAN'S NAME (Type) <u>EDWARD S. BECK MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11/13/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Zuaker</u>	22d. LOCATION (City, town, or county) (State) <u>ANNE ARUNDEL MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Bernard Hardisty</u>		ADDRESS <u>Galesville Md</u>	
24a. REC'D BY REGISTRAR <u>JO</u>		24b. REGISTRAR'S SIGNATURE <u>J. O. Smith</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be filed with the funeral director, and page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

Day, Box No.

<p>1. NAME OF DECEASED [Faint text]</p>		<p>2. SEX [Faint text]</p>		<p>3. AGE [Faint text]</p>	
<p>4. DATE OF BIRTH [Faint text]</p>		<p>5. PLACE OF BIRTH [Faint text]</p>		<p>6. OCCUPATION [Faint text]</p>	
<p>7. DATE OF DEATH [Faint text]</p>		<p>8. PLACE OF DEATH [Faint text]</p>		<p>9. CAUSE OF DEATH [Faint text]</p>	
<p>10. MEDICAL HISTORY [Faint text]</p>		<p>11. PRESENT ILLNESS [Faint text]</p>		<p>12. MANNER OF DEATH [Faint text]</p>	
<p>13. SIGNATURE OF PHYSICIAN [Faint text]</p>		<p>14. SIGNATURE OF REGISTRAR [Faint text]</p>		<p>15. SIGNATURE OF WITNESSES [Faint text]</p>	

BUREAU V. 2

NOV 16 1956

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 21

10919

1. PLACE OF DEATH o. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>SEVERNA PARK</u> b. COUNTY <u>F.A.C. 770</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS, MD</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SEVERNA PARK</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>OR INSTITUTION</u> <u>ANNE ARUNDEL</u>		d. STREET ADDRESS <u>ANNA POLIS, MD</u>	
3. NAME OF DECEASED (Type or print) <u>MINNIE PORTER</u>		4. DATE OF DEATH <u>11</u> <u>18</u> <u>1956</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/16/1893</u>
9. AGE (In years last birthday) <u>63</u> yrs.		10. IF UNDER 1 YEAR <u>1</u> Months <u>2</u> Days <u>2</u> Hours <u>2</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NEW JERSEY</u>	
11. BIRTHPLACE (State or foreign country) <u>U. S. A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>NOT KNOWN</u>		14. MOTHER'S MAIDEN NAME <u>NOT KNOWN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>MRS AGNES DAILEY NORTH WRIGHT</u>	
17. INFORMANT <u>MRS AGNES DAILEY NORTH WRIGHT</u>		Address <u>11111</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>443x Congestive Heart Failure Acute</u> DUE TO (b) <u>Hypertensive Arteriosclerotic Cardiovascular Disease 4 yrs</u> DUE TO (c) <u>Leukemia chronic</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>JAN.</u> , 19 <u>53</u> , to <u>11-18-56</u> , that I last saw the deceased alive on <u>11-12</u> , 19 <u>56</u> , and that death occurred at <u>3:24</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Francis L. Codd</u>		ADDRESS (Street, city or town, state) <u>SEVERNA PARK MD</u>	
DATE SIGNED <u>11-18-56</u>			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/21/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's</u>		22d. LOCATION (City, town, or county) (State) <u>St. Mary's</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Latham</u>		ADDRESS <u>1318</u>	
24a. REC'D BY REGISTRAR <u>Dr. Wm. French</u>		24b. REGISTRAR'S SIGNATURE <u>Dr. Wm. French</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED [REDACTED]		2. SEX [REDACTED]	
3. AGE [REDACTED]		4. DATE OF BIRTH [REDACTED]	
5. PLACE OF BIRTH [REDACTED]		6. OCCUPATION [REDACTED]	
7. MARITAL STATUS [REDACTED]		8. CAUSE OF DEATH [REDACTED]	
9. MANNER OF DEATH [REDACTED]		10. PLACE OF DEATH [REDACTED]	
11. SIGNATURE OF PHYSICIAN [REDACTED]		12. SIGNATURE OF REGISTRAR [REDACTED]	
13. DATE OF DEATH [REDACTED]		14. TIME OF DEATH [REDACTED]	
15. PLACE OF DEATH [REDACTED]		16. SIGNATURE OF WITNESS [REDACTED]	
17. SIGNATURE OF DECEASED [REDACTED]		18. SIGNATURE OF NEXT OF KIN [REDACTED]	
19. SIGNATURE OF DECEASED [REDACTED]		20. SIGNATURE OF DECEASED [REDACTED]	
21. SIGNATURE OF DECEASED [REDACTED]		22. SIGNATURE OF DECEASED [REDACTED]	
23. SIGNATURE OF DECEASED [REDACTED]		24. SIGNATURE OF DECEASED [REDACTED]	
25. SIGNATURE OF DECEASED [REDACTED]		26. SIGNATURE OF DECEASED [REDACTED]	
27. SIGNATURE OF DECEASED [REDACTED]		28. SIGNATURE OF DECEASED [REDACTED]	
29. SIGNATURE OF DECEASED [REDACTED]		30. SIGNATURE OF DECEASED [REDACTED]	
31. SIGNATURE OF DECEASED [REDACTED]		32. SIGNATURE OF DECEASED [REDACTED]	
33. SIGNATURE OF DECEASED [REDACTED]		34. SIGNATURE OF DECEASED [REDACTED]	
35. SIGNATURE OF DECEASED [REDACTED]		36. SIGNATURE OF DECEASED [REDACTED]	
37. SIGNATURE OF DECEASED [REDACTED]		38. SIGNATURE OF DECEASED [REDACTED]	
39. SIGNATURE OF DECEASED [REDACTED]		40. SIGNATURE OF DECEASED [REDACTED]	
41. SIGNATURE OF DECEASED [REDACTED]		42. SIGNATURE OF DECEASED [REDACTED]	
43. SIGNATURE OF DECEASED [REDACTED]		44. SIGNATURE OF DECEASED [REDACTED]	
45. SIGNATURE OF DECEASED [REDACTED]		46. SIGNATURE OF DECEASED [REDACTED]	
47. SIGNATURE OF DECEASED [REDACTED]		48. SIGNATURE OF DECEASED [REDACTED]	
49. SIGNATURE OF DECEASED [REDACTED]		50. SIGNATURE OF DECEASED [REDACTED]	
51. SIGNATURE OF DECEASED [REDACTED]		52. SIGNATURE OF DECEASED [REDACTED]	
53. SIGNATURE OF DECEASED [REDACTED]		54. SIGNATURE OF DECEASED [REDACTED]	
55. SIGNATURE OF DECEASED [REDACTED]		56. SIGNATURE OF DECEASED [REDACTED]	
57. SIGNATURE OF DECEASED [REDACTED]		58. SIGNATURE OF DECEASED [REDACTED]	
59. SIGNATURE OF DECEASED [REDACTED]		60. SIGNATURE OF DECEASED [REDACTED]	
61. SIGNATURE OF DECEASED [REDACTED]		62. SIGNATURE OF DECEASED [REDACTED]	
63. SIGNATURE OF DECEASED [REDACTED]		64. SIGNATURE OF DECEASED [REDACTED]	
65. SIGNATURE OF DECEASED [REDACTED]		66. SIGNATURE OF DECEASED [REDACTED]	
67. SIGNATURE OF DECEASED [REDACTED]		68. SIGNATURE OF DECEASED [REDACTED]	
69. SIGNATURE OF DECEASED [REDACTED]		70. SIGNATURE OF DECEASED [REDACTED]	
71. SIGNATURE OF DECEASED [REDACTED]		72. SIGNATURE OF DECEASED [REDACTED]	
73. SIGNATURE OF DECEASED [REDACTED]		74. SIGNATURE OF DECEASED [REDACTED]	
75. SIGNATURE OF DECEASED [REDACTED]		76. SIGNATURE OF DECEASED [REDACTED]	
77. SIGNATURE OF DECEASED [REDACTED]		78. SIGNATURE OF DECEASED [REDACTED]	
79. SIGNATURE OF DECEASED [REDACTED]		80. SIGNATURE OF DECEASED [REDACTED]	
81. SIGNATURE OF DECEASED [REDACTED]		82. SIGNATURE OF DECEASED [REDACTED]	
83. SIGNATURE OF DECEASED [REDACTED]		84. SIGNATURE OF DECEASED [REDACTED]	
85. SIGNATURE OF DECEASED [REDACTED]		86. SIGNATURE OF DECEASED [REDACTED]	
87. SIGNATURE OF DECEASED [REDACTED]		88. SIGNATURE OF DECEASED [REDACTED]	
89. SIGNATURE OF DECEASED [REDACTED]		90. SIGNATURE OF DECEASED [REDACTED]	
91. SIGNATURE OF DECEASED [REDACTED]		92. SIGNATURE OF DECEASED [REDACTED]	
93. SIGNATURE OF DECEASED [REDACTED]		94. SIGNATURE OF DECEASED [REDACTED]	
95. SIGNATURE OF DECEASED [REDACTED]		96. SIGNATURE OF DECEASED [REDACTED]	
97. SIGNATURE OF DECEASED [REDACTED]		98. SIGNATURE OF DECEASED [REDACTED]	
99. SIGNATURE OF DECEASED [REDACTED]		100. SIGNATURE OF DECEASED [REDACTED]	

REAU V. 3

OV 21 1956

RECEIVED

10943

Reg. Dist. No. 1

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Anne Arundel		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Baltimore City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City		3v01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				d. STREET ADDRESS 528 N. Carrollton Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Viola		First Middle Last Randolph		4. DATE OF DEATH 11 27 19 56		Month Day Year	
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/20/93	
9. AGE (In years last birthday) 63 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) waitress		10b. KIND OF BUSINESS OR INDUSTRY Unk.		11. BIRTHPLACE (State or foreign country) Maryland	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) waitress		10b. KIND OF BUSINESS OR INDUSTRY Unk.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME John Randolph				14. MOTHER'S MAIDEN NAME Annie Randolph			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Crownsville State Hospital Hospital Records Crownsville, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute renal failure 446X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Hypertensive Disease DUE TO (c)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hepatomegaly with Ascites		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					
20a. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20b. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11/24 , 19 56 , to 11/27 , 19 56 , that I last saw the deceased alive on 11/26 , 19 56 , and that death occurred at 2:55 a.m. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Crownsville, Maryland DATE SIGNED 11/27/56 ACTUAL SIGNATURE Lionel McHenry Mapp M.D. PHYSICIAN'S NAME (Type) Lionel McHenry Mapp							
22a. BURIAL, CREMATION, REMOVAL (Specify) 12/6/56		22b. DATE THEREOF 12/6/56		22c. NAME OF CEMETERY OR CREMATORY Mt. Auburn		22d. LOCATION (City, town, or county) (State) Baltimore Md	
23. FUNERAL DIRECTOR'S SIGNATURE G. Halstead		23a. REC'D BY REGISTRAR 12/4/56		23b. REGISTRAR'S SIGNATURE J. M. Joyce		23c. ADDRESS 918 Second Hallan	

CERTIFICATE OF DEATH

NAME OF DECEASED John H. H. H.		SEX Male		AGE 45		DATE OF BIRTH 1910	
PLACE OF BIRTH Maryland		OCCUPATION Teacher		EDUCATION High School		MARRIAGE Married	
RESIDENCE 1234 Main St., Baltimore, Md.		DATE OF DEATH 1956		PLACE OF DEATH Home		CAUSE OF DEATH Heart Disease	
MANNER OF DEATH Natural		IMMEDIATE CAUSE Myocardial Infarction		DISEASE OR INJURY Coronary Artery Disease		MEDICAL HISTORY Hypertension, Diabetes	
SIGNATURE OF PHYSICIAN Dr. J. H. H.		SIGNATURE OF WITNESS Dr. J. H. H.		SIGNATURE OF DECEASED John H. H.		SIGNATURE OF NEXT OF KIN Mrs. J. H. H.	
DATE OF SIGNATURE 1956		DATE OF SIGNATURE 1956		DATE OF SIGNATURE 1956		DATE OF SIGNATURE 1956	

BUREAU V. 5

DEC 5 1956

RECEIVED

1 INSTRUCTIONS TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10944

10951 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u> MARYLAND		STATE <u>MD</u> COUNTY <u>A.A.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena MD</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena MD</u>	
CITY OR TOWN <u>Pasadena MD</u>		LENGTH OF STAY (in this place) <u>2 yrs</u>		STREET ADDRESS <u>Ritchie Highway</u>		(If rural give location) <u>Pasadena Ind.</u>	
3. NAME OF DECEASED (First) <u>Mattie</u> (Middle) <u>K.</u> (Last) <u>Reich</u>				4. DATE OF DEATH (Month) <u>Nov.</u> (Day) <u>6</u> (Year) <u>1956</u>			
5. SEX <u>F.</u>		6. COLOR OR RACE <u>W.</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>		8. DATE OF BIRTH <u>Nov 27, 1883</u>	
9. AGE last birthday <u>72</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		11. IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>House</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore County</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Thomas L. West</u>				14. MOTHER'S MAIDEN NAME <u>Jane Butler</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u> </u> (If Yes, give war or dates of service) <u> </u>				16. SOCIAL SECURITY NO. <u> </u>			
17. INFORMANT & ADDRESS <u>Daughter</u> <u>Miss Bowes - Pasadena Md</u>							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
260x IMMEDIATE CAUSE (A) <u>Myocardial Infarction</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Generalized arteriosclerosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Diabetes mellitus</u>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While et work <input type="checkbox"/> Not while et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 1955, 19, to now, 1956, that I last saw the deceased alive on 08-20, 1956, and that death occurred at M, from the causes and on the date stated above.							
SIGNATURE <u>Robert R. Halpern</u>		ADDRESS (Street, city, town, state) <u>Severna Park Md</u>		DATE SIGNED <u>11-6-56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>11/9/56</u>		NAME OF CEMETERY OR CREMATORY <u>Good Shepherd</u>		LOCATION (City, town, or county) (State) <u>Howard Co Md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>L. J. Adlberg</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Mac Mathison</u>		ADDRESS <u>Don 28</u>	
DATE <u>NOV 9 1956</u>							

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1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

V5 A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10955

CERTIFICATE OF DEATH

10945

28

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Millersville</u>		<u>5 wks.</u>		TOWN <u>416 Sixth Ave., N.E.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Sann's Nursing Home</u>				STREET ADDRESS <u>Glen Burnie,</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
(First) <u>EDITH</u> (Middle) <u>SANNER</u> (Last)				<u>November 26, 1956</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>White</u>	<u>Single</u>	<u>Aug. 11, 1895</u>	<u>61</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Sec. (ret.)</u>		<u>U.S. Civil Serv.</u>		<u>St. Mary's County, Md.</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Richard B. Sanner</u>				<u>Nancy T. Jones</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>no</u>		<u>none</u>		<u>517 Park Ave. Mr. Carroll Sanner Towson, Md</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>Carcinoma Breast</u>						INTERVAL BETWEEN ONSET AND DEATH <u>11 mos</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Sept 19 56</u> , to <u>Nov 19 56</u> , that I last saw the deceased alive on <u>10-23</u> , 19 <u>56</u> , and that death occurred at <u>8:45</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Charles David M.D.</u>				DATE SIGNED <u>11-27-56</u>			
ADDRESS (Street, city, town, state) <u>Glen Burnie, Md</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>11/29/56</u>		<u>Woodlawn</u>		<u>Woodlawn, Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>NOV 28 1956</u>		<u>L. M. Jayes</u>		<u>Richard L. Singleton - Glen Burnie, Md.</u>			

10035 CERTIFICATE OF DEATH

Page One

NAME OF DECEASED

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BUREAU V. B.

NOV 28 1956

RECEIVED

NOV 28 1956

NOV 28 1956

NOV 28 1956

10955 CERTIFICATE OF DEATH

Reg. Dist. No.

74

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park</u>				c. LENGTH OF STAY IN 1b <u>3.5 yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cedar Rd - Carrollton Manor</u>				d. STREET ADDRESS <u>Carrollton Manor</u>			
3. NAME OF DECEASED (Type or print) <u>Aldewyn Wesley Sappington</u>				4. DATE OF DEATH <u>20 Nov.</u> 19 <u>56</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept 5 - 1882</u> 74 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Boat repair</u>		11. BIRTHPLACE (State or foreign country) <u>Anne Arundel County</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Harmon Sappington</u>				14. MOTHER'S MAIDEN NAME <u>Anna Boone</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>220-16-490</u>		17. INFORMANT <u>Severna Park Spid. Aldewyn Sappington</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral</u> <u>422.1</u> DUE TO <u>Arteriosclerotic C. V. Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>1955</u> , 19____, to <u>Nov.</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Nov. 19-56</u> , and that death occurred at <u>8:30 P</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert R. Halpin</u> M.D.				ADDRESS (Street, city or town, state) <u>Severna Park Md.</u>			
PHYSICIAN'S NAME (Type) <u>Robert R. HALPIN</u>				DATE SIGNED <u>11-20-56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11/24/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		22d. LOCATION (City, town, or county) (State) <u>BALTO., 25 Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James H. Kirkley</u>				ADDRESS <u>Hopping and Kirkley, Glen Burnie, Md.</u>		24a. REC'D BY REGISTRAR <u>NOV 26 1956</u>	
				24b. REGISTRAR'S SIGNATURE <u>L. J. DeAlba</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DEATH CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED [Faint text]</p>		<p>2. SEX [Faint text]</p>	
<p>3. AGE [Faint text]</p>		<p>4. DATE OF BIRTH [Faint text]</p>	
<p>5. PLACE OF BIRTH [Faint text]</p>		<p>6. DATE OF DEATH [Faint text]</p>	
<p>7. TIME OF DEATH [Faint text]</p>		<p>8. PLACE OF DEATH [Faint text]</p>	
<p>9. CAUSE OF DEATH [Faint text]</p>		<p>10. MANNER OF DEATH [Faint text]</p>	
<p>11. SIGNATURE OF DECEASED [Faint text]</p>		<p>12. SIGNATURE OF WITNESSES [Faint text]</p>	
<p>13. SIGNATURE OF PHYSICIAN [Faint text]</p>		<p>14. SIGNATURE OF CORONER [Faint text]</p>	
<p>15. SIGNATURE OF JURY [Faint text]</p>		<p>16. SIGNATURE OF JUDGE [Faint text]</p>	

RECEIVED
 NOV 26 1956
 BUREAU V. S.

MARYLAND

STATE DEPARTMENT OF HEALTH

10947

10957 CERTIFICATE OF DEATH

Reg. Dist. No.....

1. PLACE OF DEATH- COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>MD</u> COUNTY <u>A.A.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Arnold</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Arnold</u> <u>MD</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Dividing Cr. Rd.</u>		STREET ADDRESS (If rural, give location) <u>Dividing Cr. Rd.</u>	
3. NAME OF DECEASED (Type or Print) <u>Carmie T. Schrieffer</u>		4. DATE OF DEATH <u>Nov. 9 - 1956</u>	
5. SEX <u>F.</u>		6. COLOR OR RACE <u>W.</u>	
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>		8. DATE OF BIRTH <u>1908-1875-81</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
13. FATHER'S NAME <u>Unk.</u>		14. MOTHER'S MAIDEN NAME <u>Unk.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If year, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT AND ADDRESS <u>Daughter Mrs. Bush. (Div. Creek Rd S.P.)</u>			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
4221 Immediate cause (a) <u>Acute Pulmonary Edema</u>		
Antecedent cause(s) (b) <u>Arteriosclerotic C.V. Disease</u>		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1955, 19....., to now, 1956, that I last saw the deceasedalive on Oct 10, 1956 and that death occurred at 1204 A.M., from the causes and on the date stated above.SIGNATURE Robert R. Hahn (Degree or title) ADDRESS M.D. Severna Park Md 11-9-1956 DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>11-12-56</u>	<u>Bethesda Cemetery</u>	<u>Baltimore Md</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	FUNERAL DIRECTOR	ADDRESS
		<u>John M. Taylor Sons</u>	<u>Annapolis Md</u>

MARGIN RESERVED FOR BINDING

BUREAU V. S.

NOV 14 1956

RECEIVED

CERTIFICATE OF DEATH

10948

Reg. Dist. No.

10958

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>AA</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Shady Side</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Shady Side</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>None</u>		d. STREET ADDRESS <u>None</u>	
3. NAME OF DECEASED (Type or print) <u>James Albert Scott</u>		4. DATE OF DEATH <u>November 10 1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DEC 9 1873</u>
9. AGE (In years last birthday) <u>83</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waterman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Oyster</u>	
11. BIRTHPLACE (State or foreign country) <u>Shady Side</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Jacob Scott</u>		14. MOTHER'S MAIDEN NAME <u>Matiled Thompsons</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Address</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure - Coronary Occlusion</u> DUE TO <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>5 Years</u> DUE TO (c) <u>5 Years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypotension</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>did not see deceased during life</u> to <u>19</u> , that I last saw the deceased alive on <u>12</u> , and that death occurred at <u>2:00 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Franklin D Hendricks</u> M.D.		ADDRESS (Street, city or town, state) <u>Shady Side, Maryland</u>	
PHYSICIAN'S NAME (Type) <u>Franklin D Hendricks</u>		DATE SIGNED <u>11-11-56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11/13/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Scotts</u>	22d. LOCATION (City, town, or county) (State) <u>Shady Side Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Bernard Hardisty</u>		ADDRESS <u>Bellevue, Md</u>	
24a. REC'D BY REGISTRAR <u>10</u>		24b. REGISTRAR'S SIGNATURE <u>10</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES A. JONES		45		M		W		1880		BALTIMORE, MD.	
MARRIAGE		DATE OF MARRIAGE		PLACE OF MARRIAGE		NAME OF SPOUSE		DATE OF DEATH		PLACE OF DEATH	
MARRIED		1905		BALTIMORE, MD.		JANE A. JONES		1915		BALTIMORE, MD.	
CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION		EDUCATION		RELIGION		SPECIAL INSTRUCTIONS	
HEART DISEASE		NATURAL		LABORER		HIGH SCHOOL		METHODIST			
DATE OF DEATH		PLACE OF DEATH		NAME OF PHYSICIAN		NAME OF HOSPITAL		NAME OF BURIAL PLACE		NAME OF MINISTER	
1915		BALTIMORE, MD.		J. A. JONES		BALTIMORE HOSPITAL		GREENWOOD CEMETERY		J. A. JONES	
SIGNATURE OF PHYSICIAN		SIGNATURE OF MINISTER		SIGNATURE OF WITNESSES		SIGNATURE OF DECEASED		SIGNATURE OF SPOUSE		SIGNATURE OF NEXT OF KIN	
J. A. JONES		J. A. JONES		J. A. JONES		J. A. JONES		J. A. JONES		J. A. JONES	

BUREAU V. 2

NOV 16 1950

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THIS CERTIFICATE IS TO BE FILED IN THE DEPARTMENT OF HEALTH, BALTIMORE, MARYLAND, AND A COPY IS TO BE SENT TO THE COUNTY CLERK OF THE COUNTY IN WHICH THE DECEASED RESIDED AT THE TIME OF DEATH.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10920 CERTIFICATE OF DEATH

Reg. Dist. No.

21

1. PLACE OF DEATH o. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>A. A. Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>St. A. General Hosp.</u>				d. STREET ADDRESS <u>47 Dean Street</u>			
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>R.</u> Last <u>Sharps</u>				4. DATE OF DEATH Month <u>11</u> Day <u>6</u> Year <u>1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-28-1917</u>	9. AGE (In years last birthday) <u>38</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labourer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Annapolis, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Robert W. Sharps</u>				14. MOTHER'S MAIDEN NAME <u>Carrie E. Turner</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-12-2070</u>		17. INFORMANT Address <u>Carrie E. Turner - 47 Dean St. Annapolis, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>For Atherosclerosis & Nephrosclerosis</u> <u>199.8</u> DUE TO <u>block TV</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO <u> </u> (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u> </u> <u> </u> <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6/25</u> , 19 <u>56</u> , to <u>11/6</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>11/6</u> , 19 <u>56</u> , and that death occurred at <u>12:50 P.</u> M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Theodore H. Johnson</u> M.D.				ADDRESS (Street, city or town, state) <u>37 Cabot Street, Annapolis, Md.</u>			
PHYSICIAN'S NAME (Type) <u>Dr. THEODORE H. JOHNSON</u>				DATE SIGNED <u>Nov 13 1956</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>11-9-56</u>		<u>Brewer Hill</u>		<u>Annapolis, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese II - Annapolis, Md.</u>				24a. REC'D BY REGISTRAR <u>Nov 13 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Wm. J. French</u>	

DEATH CERTIFICATE

1. NAME OF DECEASED <i>John F. Smith</i>		2. SEX <i>Male</i>	
3. AGE <i>45</i>		4. RACE <i>White</i>	
5. DATE OF BIRTH <i>Jan 15, 1911</i>		6. PLACE OF BIRTH <i>St. Louis, Mo.</i>	
7. DATE OF DEATH <i>Nov 18, 1956</i>		8. PLACE OF DEATH <i>Home</i>	
9. TIME OF DEATH <i>10:30 AM</i>		10. CAUSE OF DEATH <i>Myocardial Infarction</i>	
11. MANNER OF DEATH <i>Natural</i>		12. SIGNATURE OF PHYSICIAN <i>Dr. J. H. Brown</i>	
13. SIGNATURE OF DECEASED <i>John F. Smith</i>		14. SIGNATURE OF WITNESSES <i>Mr. & Mrs. J. H. Brown</i>	
15. SIGNATURE OF REGISTRAR <i>John F. Smith</i>		16. SIGNATURE OF CLERK <i>John F. Smith</i>	

BUREAU V. 3

NOV 18 1956

RECEIVED

1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10950

10959

CERTIFICATE OF DEATH

Reg. Dist. No. 74

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

1. PLACE OF DEATH COUNTY <u>ANNE ARUNDEL</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>WELLSBURNE</u> LENGTH OF STAY (in this place) TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>PLAZA MANOR CONDO HOME</u>				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY CITY (If outside corporate limits, write RURAL and give nearest town) <u>Balto.</u> OR TOWN <u>3401-4</u> STREET ADDRESS (If rural give location) <u>2246 Madison Ave.</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>MARY (Corporal) SMITH</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Nov 16 19 56</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Dec 25</u>	9. AGE last birthday <u>58</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Balto. Md.</u>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Sadie Ridgeway</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Ernest Smith</u>		
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
260X IMMEDIATE CAUSE (A) <u>Bronchopneumonia</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>Diabetes Mellitus</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Hypertension</u>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> el work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Nov 14 19 56</u> to <u>Nov 16 19 56</u> , that I last saw the deceased alive on <u>Nov 14 19 56</u> and that death occurred at <u>3:15 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Walter Taler</u>		M.D. <u>Olen Burine</u>		ADDRESS (Street, city, town, state) <u>103-30th Ave. Bldg. Nov. 16, 1956</u>		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>	DATE THEREOF <u>11-19-56</u>	NAME OF CEMETERY OR CREMATORY <u>MT. AUBURN</u>		LOCATION (City, town, or county) (State) <u>BALTIMORE MD</u>			
24. REC'D BY REGISTRAR <u>Nov 20 1956</u>	REGISTRAR'S SIGNATURE <u>L. J. Dealy</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. A. Jackson Inc.</u>		ADDRESS <u>916 Penn Ave</u>		

CERTIFICATE OF DEATH

DATE OF DEATH

AT THE RESIDENCE OF THE DECEASED

DECEASED
NAME
AGE

PLACE OF DEATH

NAME OF
DECEASED
AGE

DATE

DATE OF
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NO 20 1956

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ENCLOSURE

THIS CERTIFICATE OF DEATH IS A PUBLIC DOCUMENT AND IS NOT TO BE USED FOR ANY OTHER PURPOSE. IT IS THE DUTY OF THE REGISTRAR TO SEE THAT IT IS CORRECTLY FILLED OUT AND THAT IT IS SIGNED BY THE PHYSICIAN OR OTHER PERSON QUALIFIED TO SIGN THE SAME. IT IS THE DUTY OF THE REGISTRAR TO SEE THAT IT IS FILED IN THE APPROPRIATE PLACE AND THAT IT IS AVAILABLE FOR THE PUBLIC TO VIEW. IT IS THE DUTY OF THE REGISTRAR TO SEE THAT IT IS NOT USED FOR ANY OTHER PURPOSE.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10951

10921 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>ANNE ARUNDEL</u>		STATE <u>Md.</u> COUNTY <u>A.A. Co.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>ANNAPOLIS</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>ANNAPOLIS, MD.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>A.A. GENERAL Hospt.</u>		LENGTH OF STAY (in this place)		STREET ADDRESS <u>BEST GATE</u>		(If rural give location)	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>SARAH ELLEN SMITH</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>11 12 1956</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>12/13/1886</u>	9. AGE last birthday <u>69</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOME</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSEWIFE</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN W. SEARS</u>				14. MOTHER'S MAIDEN NAME <u>MARY WOOD</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT & ADDRESS <u>THOMAS A. SMITH #2</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
420.1 IMMEDIATE CAUSE (A) <u>Posterior Myocardial Infarction</u>						INTERVAL BETWEEN ONSET AND DEATH <u>6 1/2 h.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Coronary Artery Disease</u>						<u>4 y.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>March 1953</u> , to <u>11/12/1956</u> , that I last saw the deceased alive on <u>11/12/1956</u> , and that death occurred at <u>2:30 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Frank M. Shigley</u>		M.D. <u>63 College and Annapolis</u>		DATE SIGNED <u>11/13/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>11/14/56</u>		NAME OF CEMETERY OR CREMATORY <u>EDWARDS CHAPEL</u>		LOCATION (City, town, or county) (State) <u>ANNAPOLIS MD.</u>	
24. REC'D BY REGISTRAR <u>J. V. V. V.</u>		REGISTRAR'S SIGNATURE <u>J. V. V. V.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Lytle & Sons</u>		ADDRESS <u>Annapolis, Md.</u>	
DATE							

CERTIFICATE OF DEATH

1. NAME OF DECEASED

2. SEX

3. PLACE OF DEATH

4. AGE

5. CAUSE OF DEATH

6. DATE OF DEATH

7. MEDICAL CERTIFICATION

BUREAU V. S.

NOV 16 1956

RECEIVED

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RECEIVED

NOV 30 1956

BUREAU V. B.

1. NAME OF DECEASED		2. DATE OF DEATH	
3. PLACE OF DEATH		4. TIME OF DEATH	
5. SEX		6. AGE	
7. OCCUPATION		8. MARITAL STATUS	
9. EDUCATION		10. RELIGION	
11. PLACE OF BIRTH		12. DATE OF BIRTH	
13. PLACE OF DEATH		14. TIME OF DEATH	
15. SEX		16. AGE	
17. OCCUPATION		18. MARITAL STATUS	
19. EDUCATION		20. RELIGION	
21. PLACE OF BIRTH		22. DATE OF BIRTH	
23. PLACE OF DEATH		24. TIME OF DEATH	
25. SEX		26. AGE	
27. OCCUPATION		28. MARITAL STATUS	
29. EDUCATION		30. RELIGION	
31. PLACE OF BIRTH		32. DATE OF BIRTH	
33. PLACE OF DEATH		34. TIME OF DEATH	
35. SEX		36. AGE	
37. OCCUPATION		38. MARITAL STATUS	
39. EDUCATION		40. RELIGION	
41. PLACE OF BIRTH		42. DATE OF BIRTH	
43. PLACE OF DEATH		44. TIME OF DEATH	
45. SEX		46. AGE	
47. OCCUPATION		48. MARITAL STATUS	
49. EDUCATION		50. RELIGION	
51. PLACE OF BIRTH		52. DATE OF BIRTH	
53. PLACE OF DEATH		54. TIME OF DEATH	
55. SEX		56. AGE	
57. OCCUPATION		58. MARITAL STATUS	
59. EDUCATION		60. RELIGION	
61. PLACE OF BIRTH		62. DATE OF BIRTH	
63. PLACE OF DEATH		64. TIME OF DEATH	
65. SEX		66. AGE	
67. OCCUPATION		68. MARITAL STATUS	
69. EDUCATION		70. RELIGION	
71. PLACE OF BIRTH		72. DATE OF BIRTH	
73. PLACE OF DEATH		74. TIME OF DEATH	
75. SEX		76. AGE	
77. OCCUPATION		78. MARITAL STATUS	
79. EDUCATION		80. RELIGION	
81. PLACE OF BIRTH		82. DATE OF BIRTH	
83. PLACE OF DEATH		84. TIME OF DEATH	
85. SEX		86. AGE	
87. OCCUPATION		88. MARITAL STATUS	
89. EDUCATION		90. RELIGION	
91. PLACE OF BIRTH		92. DATE OF BIRTH	
93. PLACE OF DEATH		94. TIME OF DEATH	
95. SEX		96. AGE	
97. OCCUPATION		98. MARITAL STATUS	
99. EDUCATION		100. RELIGION	

THIS IS TO CERTIFY THAT THE ABOVE IS A TRUE AND CORRECT COPY OF THE ORIGINAL RECORD AS KEPT IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MARYLAND.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10961 CERTIFICATE OF DEATH

10953

Reg. Dist. No. 28

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore City</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>		c. LENGTH OF STAY IN 1b <u>3yrs.4mos.24days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crownsville State Hospital</u>		d. STREET ADDRESS <u>3806 Fear Avenue</u>	
3. NAME OF DECEASED (Type or print) First <u>Ida</u> Middle <u>Moore</u> Last <u>Spencer</u>		4. DATE OF DEATH Month <u>11</u> Day <u>13</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/6/76</u>
9. AGE (In years last birthday) <u>80</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laundress</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>James Spencer</u>		14. MOTHER'S MAIDEN NAME <u>Ellen Ross Moore</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Hospital Records</u>		Address <u>Crownsville State Hospital</u> <u>Crownsville, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypostatic Pneumonia</u> <u>522x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Old age</u> DUE TO (c) <u>—</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Dehydration, malnutrition, decubitus ulcers</u> INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>—</u>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10/17</u> , 19 <u>56</u> , to <u>11/13</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>11/13</u> , 19 <u>56</u> , and that death occurred at <u>4:45 p.m.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Crownsville, Md.</u> DATE SIGNED <u>11/14/56</u>			
ACTUAL SIGNATURE <u>Lionel McHenry Mapp</u>		M.D. <u>Crownsville, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Lionel McHenry Mapp, M. D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>11-17-56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Lawson Memorial Cmt.</u>		22d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Clayton Wilson</u>		ADDRESS <u>1000 Pratt</u>	
24a. REC'D BY REGISTRAR <u>—</u>		24b. REGISTRAR'S SIGNATURE <u>Nathaniel Joyce</u>	
DATE <u>11-23-56</u>			

CERTIFICATE OF DEATH

Page One

1. NAME OF DECEASED John A. Smith		2. SEX Male		3. AGE 45		4. DATE OF BIRTH Jan 15, 1910		5. PLACE OF BIRTH Baltimore, Md.	
6. OCCUPATION Salesman		7. MARITAL STATUS Married		8. EDUCATION High School		9. RELIGION Roman Catholic		10. RACE White	
11. CAUSE OF DEATH Heart Disease		12. MANNER OF DEATH Natural		13. PLACE OF DEATH Home		14. DATE OF DEATH Jan 20, 1956		15. TIME OF DEATH 10:30 AM	
16. SIGNATURE OF PHYSICIAN Dr. J. H. Jones		17. SIGNATURE OF FUNERAL HOME St. Mary's		18. SIGNATURE OF WITNESS John Doe		19. SIGNATURE OF DECEASED John A. Smith		20. SIGNATURE OF NEXT OF KIN Mrs. J. A. Smith	
21. NAME OF FUNERAL HOME St. Mary's		22. ADDRESS OF FUNERAL HOME 123 Main St.		23. CITY OF FUNERAL HOME Baltimore		24. STATE OF FUNERAL HOME Md.		25. ZIP CODE OF FUNERAL HOME 21201	
26. NAME OF DECEASED John A. Smith		27. SEX Male		28. AGE 45		29. DATE OF BIRTH Jan 15, 1910		30. PLACE OF BIRTH Baltimore, Md.	
31. OCCUPATION Salesman		32. MARITAL STATUS Married		33. EDUCATION High School		34. RELIGION Roman Catholic		35. RACE White	
36. CAUSE OF DEATH Heart Disease		37. MANNER OF DEATH Natural		38. PLACE OF DEATH Home		39. DATE OF DEATH Jan 20, 1956		40. TIME OF DEATH 10:30 AM	
41. SIGNATURE OF PHYSICIAN Dr. J. H. Jones		42. SIGNATURE OF FUNERAL HOME St. Mary's		43. SIGNATURE OF WITNESS John Doe		44. SIGNATURE OF DECEASED John A. Smith		45. SIGNATURE OF NEXT OF KIN Mrs. J. A. Smith	
46. NAME OF FUNERAL HOME St. Mary's		47. ADDRESS OF FUNERAL HOME 123 Main St.		48. CITY OF FUNERAL HOME Baltimore		49. STATE OF FUNERAL HOME Md.		50. ZIP CODE OF FUNERAL HOME 21201	

RECEIVED
JAN 23 1956
BUREAU V. 6

10962 CERTIFICATE OF DEATH

Reg. Dist. No. 26

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pr. Geo's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Deale</u>				c. LENGTH OF STAY IN 1b <u>Transient</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Deale Road</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Upper Marlboro</u>			
				d. STREET ADDRESS <u>Rt. 2., Box 287</u>			
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>William</u> Last <u>Sturgess</u>				4. DATE OF DEATH Month <u>November</u> Day <u>23</u> Year <u>1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 17, 1877</u>	9. AGE (In years last birthday) <u>79</u> yrs.	10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		11. IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Tobacco Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Farm</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>Samuel Sturgess</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Windsor</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u> </u>			
17. INFORMANT <u>James E. Sturgess</u>				Address <u>Rt. 2, Box 287, Upper Marlboro, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis. C.V. Disease</u> DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>5 min.</u> <u>Unk.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>Sept</u> , 19 <u>36</u> , to <u>23 hr</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>19 hr</u> , 19 <u>56</u> , and that death occurred at <u>11:27 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J. B. Sasser</u>				ADDRESS (Street, city or town, state) <u>Upper Marlboro, Maryland</u>			
DATE SIGNED <u>11/23/56</u>							
PHYSICIAN'S NAME (Type) <u>R. B. Sasser, M. D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/27/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Trinity Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Upper Marlboro, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ritchie Bros.</u>				ADDRESS <u>Upper Marlboro, Maryland</u>		24a. REC'D BY REGISTRAR <u>Nov 30-1956-G. B. Bent</u>	
24b. REGISTRAR'S SIGNATURE							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10955

10963

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>aa</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>aa</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		TOWN	
TOWN <u>Arnold</u>				TOWN <u>Arnold</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Edith</u> (First) <u>Elizabeth</u> (Middle) <u>Shieme</u> (Last)				<u>11-17-1956</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>White</u>	<u>Married</u>	<u>2-23-1894</u>	<u>62</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY	
<u>Housewife</u>			<u>None</u>	<u>Prince George Co Md</u>		<u>U. S. A</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>James Arnold</u>				<u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS	
						<u>Alvin Shieme</u> (2)	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
334X IMMEDIATE CAUSE (A) <u>Apoplexy due to Paralysis of the</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO (B) <u>throat</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Hypertension - Apoplexy.</u>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> al work Not while <input type="checkbox"/> al work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>April 9</u> , 19 <u>54</u> , to <u>Nov. 16</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Nov. 16</u> , 19 <u>56</u> , and that death occurred at <u>6:30 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>T. G. De Ouedo</u> M.D.				ADDRESS (Street, city, town, state) <u>Arnold - Md</u>		DATE SIGNED <u>Nov. 19, 1956</u>	
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>11-19-56</u>		<u>Asbury Memorial</u>		<u>Arnold Md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>11-21-56</u>		<u>Wm. French</u>		<u>John W. De Ouedo</u>		<u>Arnold Md</u>	

CERTIFICATE OF DEATH

1. Usual Residence (If not specified, as printed)

PLACE OF DEATH

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CITY

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2. Medical Certification

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10922

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

21

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>60 Larkin St</u>				d. STREET ADDRESS <u>60 Larkin St</u>			
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>Thomas</u> Last <u>Thomas</u>				4. DATE OF DEATH Month <u>11</u> Day <u>12</u> Year <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Gold</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-11-1866</u>	
9. AGE (In years last birthday) <u>90</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Handyman</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Rutland, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>John Henry Thomas</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Thomas</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Mary Thomas - 60 Larkin St</u> Address <u> </u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arteriosclerosis generalized</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u> </u> (c), stating the underlying cause lost. DUE TO <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u> </u> o. m. <u> </u> p. m. <u> </u> Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>E. L. Linhardt</u> EXAMINER'S NAME (Type) <u>E. L. Linhardt</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
DATE SIGNED <u>11/12/56</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-15-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Brewer Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese, Jr</u>				ADDRESS <u>Annapolis, Md</u>		24a. READ BY REGISTRAR DATE <u>Nov. 15, 1956</u>	
				24b. REGISTRAR'S SIGNATURE <u>Am. J. French</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
Items 10964 8,9: fd 11-27-56 L					10957				
Reg. Dist. No.									
1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Linthicum c. LENGTH OF STAY IN 1b 14 years d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Hammonds Ferry Road Box 272					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Same b. COUNTY Same c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Same d. STREET ADDRESS Same e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Middle Last Richard Celestine Towson (TOWSON)					4. DATE OF DEATH Month Day Year November 22 19 56				
5. SEX M		6. COLOR OR RACE W.		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6/19/56 1881		9. AGE (In years last birthday) 75 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retires carpenter			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) Baltimore Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Towson					14. MOTHER'S MAIDEN NAME Estelle ?				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-05-2988		17. INFORMANT Address Mrs Estelle Towson (wife)					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH Sudden									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE Gustave H. Faubert					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) Gustave H. Faubert M.D.					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 11/23/56				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 26-56		22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery			22d. LOCATION (City, town, or county) (State) Baltimore City Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE Richard P. Long					ADDRESS Glen Burnie		24a. REC'D BY REGISTRAR 146 NOV 27 1956		24b. REGISTRAR'S SIGNATURE R. H. Redusich

MASS AND STATE DEPARTMENT OF HEALTH - BOSTON 10
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
NOV 27 1956
BUREAU V. 5

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filled with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10958

10923 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>AA</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>AA</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>ANNAPOLIS</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Arundel on the Bay</u>		TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>AA GENERAL</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>WALTER L.</u> (Middle) <u>TYLER</u> (Last)				(Month) <u>11</u> (Day) <u>24</u> (Year) <u>56</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widower</u>	8. DATE OF BIRTH <u>Mar. 18-1877</u>	9. AGE last birthday <u>79</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Civil Service Carpenter U.S. Naval Academy</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE Md. U.S.A</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Albert L. Tyler</u>				14. MOTHER'S MAIDEN NAME <u>Katharine Mason</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If Yes, give war, dates of service) <u>No Spanish American War</u>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Mrs Clifford H Jones Annapolis Md. 692 State St</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>4200 Azytemia</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u>			
ANTECEDENT CAUSE(S) DUE TO				<u>Chronic nephritis</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				DUE TO <u>Arterio-sclerotic Heart Disease</u>			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				<u>Coronary Thrombosis</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Oct. 1, 1956</u> , to <u>Nov. 24, 1956</u> , that I last saw the deceased alive on <u>11-28-56</u> , 19 <u>56</u> , and that death occurred at <u>10:45</u> M, from the causes and on the date stated above.							
SIGNATURE <u>James H. Martin</u>		M.D. <u>185 Pine Street Baltimore Md</u>		ADDRESS (Street, city, town, state) <u>11/26/56</u>		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Removal</u>		DATE THEREOF <u>11-27-56</u>		NAME OF CEMETERY OR CREMATORY <u>HILLCREST</u>		LOCATION (City, town, county) (State) <u>ANNAPOLIS MD</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>J. D. Smith</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor</u>		ADDRESS <u>692 State St Annapolis Md.</u>	
DATE							

CERTIFICATE OF DEATH

1956

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. MARITAL STATUS

8. RACE

9. RELIGION

10. EDUCATION

11. SOCIAL SECURITY NUMBER

12. DATE OF DEATH

13. TIME OF DEATH

14. PLACE OF DEATH

15. CAUSE OF DEATH

16. MANNER OF DEATH

17. SIGNATURE OF PHYSICIAN

18. SIGNATURE OF REGISTRAR

19. SIGNATURE OF WITNESSES

20. SIGNATURE OF DECEASED

21. SIGNATURE OF NEXT OF KIN

22. SIGNATURE OF BURIAL SOCIETY

23. SIGNATURE OF FUNERAL HOME

24. SIGNATURE OF CEMETERY

25. SIGNATURE OF CHURCH

26. SIGNATURE OF MINISTRY

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BUREAU V. 1

10V 28 1956

RECEIVED

NOTIFICATION

1. NAME OF DECEASED
2. SEX
3. AGE
4. DATE OF BIRTH
5. PLACE OF BIRTH
6. OCCUPATION
7. MARITAL STATUS
8. RACE
9. RELIGION
10. EDUCATION
11. SOCIAL SECURITY NUMBER
12. DATE OF DEATH
13. TIME OF DEATH
14. PLACE OF DEATH
15. CAUSE OF DEATH
16. MANNER OF DEATH
17. SIGNATURE OF PHYSICIAN
18. SIGNATURE OF REGISTRAR
19. SIGNATURE OF WITNESSES
20. SIGNATURE OF DECEASED
21. SIGNATURE OF NEXT OF KIN
22. SIGNATURE OF BURIAL SOCIETY
23. SIGNATURE OF FUNERAL HOME
24. SIGNATURE OF CEMETERY
25. SIGNATURE OF CHURCH
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102. SIGNATURE OF OTHER

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filed with the funeral director, and page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10959

10924 CERTIFICATE OF DEATH

Reg. Dist. No 21

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Riva Anne Arundel General Hospital</u>				d. STREET ADDRESS <u>Riva</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>E</u> Last <u>Van Wart</u>				4. DATE OF DEATH Month <u>November</u> Day <u>9</u> Year <u>19 56</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 12, 1882</u>	
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired - Supt.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Apt. House</u>		11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>101-03-0071</u>		17. INFORMANT Address <u>Mrs. Alice Stanton- Daughter- same as # 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction, antero-septal</u> DUE TO <u>Coronary artery occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary atherosclerosis.</u> (c) <u>Coronary atherosclerosis.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>420.1</u> INTERVAL BETWEEN ONSET AND DEATH							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>11/8</u> , 19 <u>56</u> , to <u>11/9</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>11/9</u> , 19 <u>56</u> , and that death occurred at <u>5:00</u> A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>90 Cathedral St. Annapolis, Md.</u> DATE SIGNED <u>11/9/56</u>							
ACTUAL SIGNATURE <u>John H. Hedeman</u>				M.D. <u>90 Cathedral St. Annapolis, Md.</u>			
PHYSICIAN'S NAME (Type) <u>John Hedeman MD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal-Burial</u>		22b. DATE THEREOF <u>11-13-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Maspeth, Long Island, New York</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping Funeral Home</u>				ADDRESS <u>172 West St. Annapolis, Md.</u>		24a. REC'D BY REGISTRAR <u>13 1956</u>	
24b. REGISTRAR'S SIGNATURE <u>Wm. J. Funch</u>							

RECEIVED
NOV 18 1956
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10965 CERTIFICATE OF DEATH

10960

Reg. Dist. No.

28

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTO</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CROWNSVILLE, ANNAPOLIS</u>				c. LENGTH OF STAY IN 1b <u>9 YRS 5 MOS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>CROWNSVILLE STATE</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>MARY Antoinette WADE</u>				4. DATE OF DEATH <u>NOV 17 1956</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>NOV 8, 1885</u>	9. AGE (In years last birthday) <u>71</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>UNKNOWN</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MD</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>WALTER HENRY F. WADE</u>				14. MOTHER'S MAIDEN NAME <u>ANNA Legion</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO.		17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HEART FAILURE</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>AURICULAR FIBILLATION</u> DUE TO (c) <u>ARTEROSCLEROTIC CARDIOVASCULAR DISEASE</u>							INTERVAL BETWEEN ONSET AND DEATH <u>approx 48 hrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>MALNUTRITION</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>NOV 15</u> , 19 <u>56</u> , to <u>NOV 17</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>NOV 17</u> , 19 <u>56</u> , and that death occurred at <u>7:45 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>George McK Phillips</u> M.D.				ADDRESS (Street, city or town, state) <u>Crownsville Md</u>			
PHYSICIAN'S NAME (Type) <u>GEORGE A. MCK PHILLIPS</u>				DATE SIGNED <u>11-18-56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-20-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>arbutus</u>		22d. LOCATION (City, town, or county) (State) <u>md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>George S. Nelson</u> ADDRESS <u>1348 N. Calhoun St</u>				24a. REC'D BY REGISTRAR <u>DATE 191956</u>		24b. REGISTRAR'S SIGNATURE <u>R. M. Joyce</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

10925

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>AA. Co</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Mo.</u> b. COUNTY <u>AA. Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>179 GREEN ST.</u>				d. STREET ADDRESS <u>179 GREEN ST.</u>			
3. NAME OF DECEASED (Type or print) First <u>SUSIE</u> Middle <u>R.</u> Last <u>WARD</u>				4. DATE OF DEATH Month <u>NOV.</u> Day <u>25</u> Year <u>1956</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/14/1888</u>	9. AGE (In years last birthday) <u>68</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOME</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSEWIFE</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>"Unk"</u>				14. MOTHER'S MAIDEN NAME <u>"Unk"</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>MRS. ROSIE SCURRY</u> Address <u>#2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>HYPERTENSIVE CARDIO-VASCULAR DIS.</u> DUE TO (c) <u>10 YRS.</u>						INTERVAL BETWEEN ONSET AND DEATH <u>MINUTES</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>JAN.</u> , 19 <u>56</u> , to <u>NOV. 25</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>25 NOV.</u> , 19 <u>56</u> , and that death occurred at <u>11 AM.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>41 Southgate AVE ANNAPOLIS</u> DATE SIGNED <u>11/29/56</u> ACTUAL SIGNATURE <u>Edward S Beck</u> M.D. PHYSICIAN'S NAME (Type) <u>EDWARD S BECK MD</u> <u>MARYLAND</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11/29/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>CEDAR Bluff</u>		22d. LOCATION (City, town, or county) (State) <u>ANNAPOLIS MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Kyfor + Sons</u> ADDRESS <u>Annopolis, Md.</u>				24a. REC'D BY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

PLACE OF DEATH		DATE OF DEATH	
HOME		JAN 2 1956	
COUNTY		CITY	
BALTIMORE		BALTIMORE	
STREET		AGE	
1234 E. BALTIMORE		65	
CITY		SEX	
BALTIMORE		M	
STATE		OCCUPATION	
MD		LABORER	
COUNTRY		EDUCATION	
USA		HIGH SCHOOL	
MARRIAGE		RELIGION	
MARRIED		CATHOLIC	
SPOUSE		CAUSE OF DEATH	
JANE DOE		HEART DISEASE	
MOTHER		MANNER OF DEATH	
MARY SMITH		NATURAL	
FATHER		CERTIFICATE NO.	
JOHN DOE		12345	
SISTER		REGISTERED	
SARAH DOE		DATE	
BROTHER		JAN 2 1956	
MICHAEL DOE		BY	
Nephew		J. SMITH	
Uncle		J. SMITH	
Aunt		J. SMITH	
Grandmother		J. SMITH	
Grandfather		J. SMITH	
Sister-in-law		J. SMITH	
Brother-in-law		J. SMITH	
Niece		J. SMITH	
Nephew		J. SMITH	
Other		J. SMITH	

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1956 JAN 07

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be returned to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

10966

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12086

Reg. Dist. No. 28

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE _____ b. COUNTY _____	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GAMBRILLS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) _____	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) _____		d. STREET ADDRESS _____	
3. NAME OF DECEASED (Type or print) <u>MARY</u> First <u>WARREN</u> Middle <u>WARREN</u> Last		4. DATE OF DEATH Month <u>11</u> Day <u>12</u> Year <u>1956</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH _____
9. AGE (In years last birthday) <u>53</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) _____		10b. KIND OF BUSINESS OR INDUSTRY _____	
11. BIRTHPLACE (State or foreign country) _____		12. CITIZEN OF WHAT COUNTRY? _____	
13. FATHER'S NAME _____		14. MOTHER'S MAIDEN NAME _____	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) _____		16. SOCIAL SECURITY NO. _____	
17. INFORMANT _____		Address _____	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Skull Fracture</u> <u>812 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Fracture of neck</u> (c) <u>Compressed and comminuted Fractures of both lower legs</u> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____ WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Pedestrian hit by auto</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>11:30</u> am. <u>11/11/56</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>street</u>		20f. (City or town) <u>Anne Arundel Md</u> (County) _____ (State) _____	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>William Upchurch</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) _____		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>11-12-56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12.21.56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>C. of Md. Med. School</u>		22d. LOCATION (City, town, or county) <u>Baltimore, Md.</u> (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE _____		24a. REC'D BY REGISTRAR <u>DEC 26 1956</u> DATE	
24b. REGISTRAR'S SIGNATURE <u>A. M. Joyce</u>			

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. OCCUPATION		5. MARITAL STATUS		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH	
10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF MEDICAL EXAMINER	
13. SIGNATURE OF REGISTRAR		14. SIGNATURE OF CLERK		15. SIGNATURE OF JURY	
16. SIGNATURE OF WITNESS		17. SIGNATURE OF JURY		18. SIGNATURE OF JURY	
19. SIGNATURE OF JURY		20. SIGNATURE OF JURY		21. SIGNATURE OF JURY	
22. SIGNATURE OF JURY		23. SIGNATURE OF JURY		24. SIGNATURE OF JURY	
25. SIGNATURE OF JURY		26. SIGNATURE OF JURY		27. SIGNATURE OF JURY	
28. SIGNATURE OF JURY		29. SIGNATURE OF JURY		30. SIGNATURE OF JURY	
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40. SIGNATURE OF JURY		41. SIGNATURE OF JURY		42. SIGNATURE OF JURY	
43. SIGNATURE OF JURY		44. SIGNATURE OF JURY		45. SIGNATURE OF JURY	
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76. SIGNATURE OF JURY		77. SIGNATURE OF JURY		78. SIGNATURE OF JURY	
79. SIGNATURE OF JURY		80. SIGNATURE OF JURY		81. SIGNATURE OF JURY	
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91. SIGNATURE OF JURY		92. SIGNATURE OF JURY		93. SIGNATURE OF JURY	
94. SIGNATURE OF JURY		95. SIGNATURE OF JURY		96. SIGNATURE OF JURY	
97. SIGNATURE OF JURY		98. SIGNATURE OF JURY		99. SIGNATURE OF JURY	
100. SIGNATURE OF JURY		101. SIGNATURE OF JURY		102. SIGNATURE OF JURY	

RECEIVED
DEC 27 1956
BUREAU V. S.

10926 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Q. Q.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Q. Q.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>South River Park</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>A. A. General Hosp.</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>N.</u> Last <u>Williams</u>		4. DATE OF DEATH Month <u>11</u> Day <u>15</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 31-1904</u>
9. AGE (In years last birthday) <u>52</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Stores</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington DC</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>William Williams</u>		14. MOTHER'S MAIDEN NAME <u>Flora Smith</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>Work Unit</u>	
17. INFORMANT <u>Marion H. Williams</u>		Address <u>(2)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive cardiovascular Disease</u> DUE TO (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 minutes</u> <u>2 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>11/2</u> , 19 <u>56</u> , to <u>11/15</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>11/15</u> , 19 <u>56</u> , and that death occurred at <u>7 A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John L. Hedeman</u>		ADDRESS (Street, city or town, state) <u>90 Cathedral St. Annapolis, Md.</u>	
PHYSICIAN'S NAME (Type) <u> </u>		DATE SIGNED <u>11/16/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11-17-56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Washington National</u>	22d. LOCATION (City, town, or county) (State) <u>Annapolis Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor Sins Annapolis Md</u>		24a. REC'D BY REGISTRAR <u> </u> 24b. REGISTRAR'S SIGNATURE <u> </u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Item 11 FilmG207 11-21-56 et

10967 CERTIFICATE OF DEATH

10963

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anarundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Arundel</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Millersville</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Herald Harbor</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Ganns Nursing Home.</u>				STREET ADDRESS (If rural give location) <u></u>			
3. NAME OF DECEASED (Type or Print) <u>Frederick W. Willner</u>				4. DATE OF DEATH (Month) <u>November</u> (Day) <u>12th</u> (Year) <u>1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, <u>Married</u>	8. DATE OF BIRTH <u>May 8, 1874</u>	9. AGE last birthday <u>82</u> yrs.	IF UNDER 1 YEAR Months <u></u> Days <u></u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Francis H Willner</u>				14. MOTHER'S MAIDEN NAME <u>Frances Mulligan</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Warren H Willner-Herald Harbor, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
450.0 IMMEDIATE CAUSE (A) <u>Generalized Arteriosclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>5 Years</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
104.7 (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Fractured Left Femur</u>						4 Mo	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <u></u>		21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Sept</u> , 19 <u>56</u> , to <u>Nov 12</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Nov 12</u> , 19 <u>56</u> , and that death occurred at <u>8:45 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Edward G. Bennett</u>		M.D. <u>Baltimore Md</u>		DATE SIGNED <u>11-12-56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>11-14-56</u>		NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		LOCATION (City, town, or county) (State) <u>Suitland, Md.</u>	
24. REC'D BY REGISTRAR <u>Nov 14 1956</u>		REGISTRAR'S SIGNATURE <u>J. M. Joyce</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>J. W. Lee's Sons Co. Wash D.C.</u>		ADDRESS	

